



Emerald City Behavioral Health  
Address: 3713 Pacific Ave, Tacoma, WA 98418  
Phone: 253-433-7993 Fax: 253-540-6886

### Release of Information

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize Emerald City Behavioral Health to release and exchange information regarding my mental health and substance use treatment records with the following individual or organization:

Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone/Fax #: \_\_\_\_\_

**The information to be disclosed includes:** (initial or write NO)

- \_\_\_\_\_ Assessment and Diagnosis
- \_\_\_\_\_ Treatment Plan and Progress Notes
- \_\_\_\_\_ Medication Records
- \_\_\_\_\_ Discharge Summary
- \_\_\_\_\_ Lab Results
- \_\_\_\_\_ Appointment Attendance
- \_\_\_\_\_ Billing and Insurance Information
- \_\_\_\_\_ Other: \_\_\_\_\_

**Reason for Disclosure:** (initial or write NO)

- |                            |                             |
|----------------------------|-----------------------------|
| _____ Coordination of Care | _____ Treatment Planning    |
| _____ Legal Purposes       | _____ Disability Claims     |
| _____ Housing Assistance   | _____ Employment Assistance |
| _____ Educational Support  | _____ Personal Request      |
| _____ Other: _____         |                             |

This authorization is valid until (date): \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time by providing written notice to Emerald City Behavioral Health, except to the extent that action has already been taken in reliance on this authorization.

I understand that my treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that once information is disclosed, it may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the client is unable to sign, please indicate the legal representative's information:

Representative's Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Representative Signature: \_\_\_\_\_