EXCELSIOR

3754 W Indian Trail Rd, Spokane, WA 99208
Phone: 509-559-3160 Fax: 509-328-7582 Email:
admissions@excelsiorwellness.org

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Printed Name of Service Participant: _____ Birthdate: _____

EXCELSIOR	**Entity or Individual** (One Per Sheet)	**Check one choice below:**
3754 W Indian Trail Rd Spokane, WA 99208 Phone: 509-559-3100 Fax: 509-328-7582	_____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	☐ Mutual Disclosure between the Entity/Individual and Excelsior ☐ Excelsior may disclose to Entity/Individual listed ☐ Entity/Individual may disclose to Excelsior

The purpose or need for the exchange and disclosure of this information is to: (BE SPECIFIC check all that apply.)

☐ Facilitate Treatment	☐ Coordinate Continuing Care	☐ Other (please specify)
☐ Summarize Treatment	☐ Legal	_____

Information to be disclosed: Choose from one of the following columns.

Choice A - All Information		**Choice B - Specific Information**	
☐ I authorize the disclosure of **ALL** information.	**OR**	☐ I authorize only the following information to be released	
Information to **EXCLUDE:** Be specific: _____ _____		☐ Identity ☐ Dates of Service ☐ Assessment/Diagnosis ☐ Discharge Summary ☐ Medical Orders ☐ Mental Health Records	☐ Physical Health Records ☐ Psychiatric Orders ☐ Substance Use Treatment ☐ Transition Report ☐ Treatment Plan ☐ Urinalysis/Breathalyzer Results

I understand that my records are protected under federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2 and the Health Insurance Portability Act of 1996 (HIPAA), 45 CFR pts 160 and 164. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases (e.g., Tuberculosis, HIV/AIDS), mental health services, drug and/or alcohol services. I understand that my records cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke this consent at any time unless action has been taken in reliance on it. I understand that information used or disclosed under this authorization has the potential of being re-disclosed by another party and thereby no longer protected. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain enrollment, treatment, or payment unless otherwise required or indicated in the provision of quality care. This authorization expires on:_____ (If no date or event is identified, the authorization will terminate 60 days after the last treatment or evaluation session I attend.)

SIGNATURE:_____ **DATE:** _____

Note: Minors Ages 13-17 Must Sign: *A minor's signature is required in order to release the following information: (1) conditions related to the minor's reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization and sexually transmitted disease (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older)*

Legal Guardian's signature (for 12 and younger): _____

Print Name: _____ Relationship: _____ DATE: _____

OFFICE USE

Accepted By: _____ Date: _____
[Print Excelsior Staff Name]