Please return to:
Pearl Street Center- Comprehensive Life Resources
Attn: Mary Paden
815 S. Pearl Street
Tacoma, WA 98465
Phone: (253-396-5936 Fax: (253) 566-2252

CLR STAFF USE ONLY

_____

Staff assisting in form completion

☐ ***File only (no action required)***

CONSUMER AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please allow up to fifteen (15) days for processing.

(a) Client ID#: **Client Name:** **D.O.B:**

(b) I hereby authorize Comprehensive Life Resources to:

☐ **Copy my CLR records and send them to:**

☐ **Request medical/mental health/educational/ financial and/or other type of records FROM the listed provider and have them sent to CLR**

☐ **Verbal Exchange Only**

***Person/Provider:** _____

Relationship to Consumer: _____

***Street Address:** _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

(c) Please check (initials preferred) all records that you would like released to or requested from (including verbal) an outside source:

Behavioral Health	**Medical**	**Education/School**	**Dental**
__ Assessments (5 yrs back)	__ EPSDT/Well Child Exam	__ IEP Records	__ Office Notes
__ Psychiatric Assessments (5 yrs back)	__ Admission Information	__ Grades	__ Other: _____
__ Discharge Summary (5 yrs back)	__ Discharge Summary	__ Other: _____	**Other:**
__ Crisis Plans (5 yrs back)	__ Medication Records		__ Financial Records
__ Prescribing/Medication (5 yrs back)	__ Progress Notes		__ Other: _____
__ Other: _____	__ Other: _____		

(d) In addition to Mental Health information, I specifically authorize the disclosure of information related to the testing, diagnosis and treatment of the following type(s) of healthcare conditions:

☐ **HIV/AIDS/Sexually Transmitted Diseases** ☐ **Chemical/Alcohol Abuse and/or Dependency**

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

(e) Authorization Expiration (45 CFR 164.508c & RCW 70.02.030):

Expiration Date: This authorization will be in effect until I am no longer receiving services at CLR and will remain in effect 90 days after termination of services to facilitate coordination of my ongoing care.

If I am under Department of Corrections or court order to receive behavioral health services, this authorization expires when I am no longer under supervision or required participation.

If I have authorized release of information to a financial institution or employer for purposes other than payment, this authorization shall expire automatically one year after the date of signature unless I extend the expiration date or I am not in treatment.

Client specified Expiration Date: _____

(f) **Disclosure of Information** is for continuity of care unless otherwise specified below:

☐ Legal ☐ Financial ☐ Other:_____

(g) **HIPAA:** I understand that: 1) I have the right to refuse to sign this authorization and that, if I do not complete and sign the authorization, the information cannot be released; 2) CLR is not allowed to withhold treatment, enrollment or payment or eligibility for benefits if I do not sign this authorization; 3) that after the information I have authorized is received by a person or a provider, my information might be re-disclosed by the receiving party and then may not by protected by law; 4) I may revoke or cancel this authorization at any time, but I cannot revoke a release that already happened before I cancelled. I know I must revoke in writing and submit it to CLR.

(h) Consumer Signature: _____ **Date**: _____

(i) Representative Signature: _____ **Date:** _____

Relationship to Consumer: _____

(Consumer must sign own consent if 13 years old or older)

A copy or FAX of this ROI shall be considered valid in lieu of the original. A charge for the reproduction (copy) of medical records may be assessed. Last revised: 4/21/17

Release of Information Form Completion Instructions

A Release of Protected Information (PHI) gives Pearl Street Center (PSC) -Comprehensive Life Resources (CLR) permission to talk to people you choose about your services. This allows us to coordinate your care.

1. In Section (a), write your First and Last name and then your Date of Birth (D.O.B) in the appropriate fields. We will complete the Client ID if you don't know it.

2. In Section (b), check only one box, telling us what action you want us to take:

   a. The top box means that you want us to make a copy of the records that we have for you here at CLR and release them to the person or provider that you indicate on the Release.

   b. The middle box will allow CLR to get copies of your medical records from your other providers. For example, we would fax your completed Release to your primary care provider and they would fax or mail us a copy of your medical records.

   c. The bottom box will allow us to release and receive information only verbally about you. For example, it will allow us to talk directly or by phone to your family member, a friend or someone else you choose.

3. In Section (d), check either or both boxes (HIV/STDs and Chemical/Alcohol Abuse) if you want this type of information included in this Release request. If you don't check either of these boxes, this type of information will not be released or requested by us.

4. Section (e) says your authorization expires automatically ninety days after you are no longer in service or, if you are under court order or corrections supervision, it expires when legal restrictions are no longer in effect. Read Section (e) for other expiration information. If you want a different expiration date, please write it on the "Client Specified Expiration Date" line. You may revoke or cancel the authorization at any time if there are no legal restrictions.

5. If disclosure of information is not for continuity of care, check any of the boxes in Section (f). If you check, "Other" write what that is.

6. Section (g) explains your Health Insurance Portability and Accountability Act (HIPAA) rights. Please read them.

7. If you are age thirteen or older, sign and date the form in Section (h). If you are younger than thirteen or are not the client, you may complete Section (i) instead.

8. Section (i), if you have Power of Attorney, are a Court Appointed Guardian or have other documents that grant you authority to authorize release of information for the client named here, please sign and date this form. Write your relationship to the client. PLEASE NOTE: We will need a copy of documents that grant you authority to release or receive information to honor the request.

9. You may fax the Request to (253) 566-2252 or mail it to: Pearl Street Center, Attn: Mary Paden, 815 South Pearl Street, Tacoma, WA 98465. If you have questions about the Release form or process, please call Mary at 253-396-5936. If you would like a paper copy of our blank Release form mailed to you, call (253) 396-5936.