TAMARACK CENTER
Authorization for Release of Information

Name	Birth Date		ID#
Street Address	City	State	Zip Code

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individual Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records my contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDs – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I understand that I may revoke this authorization at any time by notifying Tamarack Center in writing and that it will not impact my access for treatment or services.

I hereby authorize Tamarack Center to (check all that apply):

_____ Exchange with _____ Release to

Purpose for Release of Information: _____

_____

Person/organization receiving/communicating the information:

Name: _____

Address: _____

Phone Number: (_____)_____

Description of individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:

_____ Financial Information: (Specific Request) _____

_____

_____ Clinical Information: (Specific Request) _____

_____

_____ Other (describe) _____

_____

PLEASE READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire one year from the date of signature below in the State of Washington (or as set forth by other applicable federal or state law).
(Form must be completed before signing)

_____	_____	_____
Resident	Legal Guardian	Date

_____	_____
Privacy Officer or Designee	Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION