

RIVER VALLEY PSYCHOLOGICAL SERVICES

5837 221ST PL SE
ISSAQUAH, WA
98027

TELEPHONE (425) 391-0887 FAX (425) 391-7014

AUTHORIZATION FOR RIVER VALLEY PSYCHOLOGICAL SERVICES TO USE OR DISCLOSE MY HEALTH CARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name(s): _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health Care information In my medical record relating to the following treatment or condition

- Health care information for the date(s): _____
- Other (e.g. bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis and treatment for (check all that apply):

- HIV (Aids virus)
- Sexually transmitted disease
- Psychiatric disorders/mental health
- Drug and/or alcohol use

You may disclose this health care information to from (check boxes that apply):

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Reason(s) for this authorization (check all that apply):

- At my request
- Other (specify): _____
- This authorization ends on: ____/____/____
(This document does not permit disclosure of health information created more than one year after the date signed)
- In one year from date signed
- When the following event occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to get my health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- ♦ To take part in a research study or
- ♦ To receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by River Valley Psychological Services based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
 - ♦ Fill out a revocation form. A form is available from River Valley Psychological Services or
 - ♦ Write a letter to River Valley Psychological Services.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws no longer protect it.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)