RIVER VALLEY PSYCHOLOGICAL SERVICES

600 OAKESDALE AVENUE SW #104
RENTON, WA 98057
TELEPHONE (425) 228-5336 **FAX** (425) 228-4540

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