LOURDES
Behavioral Health

1175 Carondelet Drive Richland, WA 99354

Authorization to Disclose Health Information

I. I authorize disclosure of the following information (check appropriate boxes below):

✓	Record Type	Dates	
	Assessment/Intake/Admission Note	To	From
	Treatment Attendance/Compliance		
	Psychotherapy Notes/Treatment Plan		
	Crisis/Desert Hope		
	Letters/forms		
	Other (specify below)		

II. I would like the following information *included* in the materials disclosed (check applicable boxes below:

___Alcohol/Drug abuse.
___Mental health
___Sexually transmitted disease
___HIV/AIDS

III. *If any of these boxes is checked, the following notification applies*:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

IV. I would like the information described above prepared using the following process:

______Photocopy _____Electronic File ____Compact Disc (Radiology Images)

V. I would like the information described above delivered using the following process:

___Mailed ___Sent via secure e-mail

VI. I understand that:

A. Authorizing a disclosure of health information is voluntary. Trios Health will not condition treatment on my providing this authorization.
B. I have the right to revoke this authorization at any time by providing written notice to the Medical Record/Health Information Management Department.
C. If I revoke this authorization, the revocation will not apply to information that has already been disclosed in reliance on this authorization.

VII. Once information is disclosed, it may be subject to re-disclosure by the recipient and may not be protected by federal and state privacy laws. This authorization will expire on (insert date). If not specified, this authorization will expire 365 days from when it was signed.

Patient's Name

Patient's Birthdate:

Phone Number:

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VI. **I would like the information above disclosed from and to the individuals or organizations below:**

✓	FROM	✓	TO
☐	Lourdes Behavioral Health	☐	Name of person or organization ________________________________ Street Address________________________________ City, State, Zip________________________________ FAX ______________ Phone ______________ E-mail address________________________________
☐	Name of person or organization ________________________________ Street Address________________________________ City, State, Zip________________________________ FAX ______________ Phone ______________ E-mail address________________________________	☐	Lourdes Behavioral Health

Purpose of Requested Disclosure:

- ☐ Continuity of Care
- ☐ Insurance
- ☐ Attorney
- ☐ Personal Records
- ☐ Other :____

CHARGES MAY BE APPLIED FOR RECORDS REQUESTS

________________________________ ________________________________ ______________

Signature of Patient or Legal Representative   Relationship to Patient   Date

FOR OFFICE USE ONLY

Patient ID ☐ Driver's License #________________________ ☐ Other: ________________________ ID of Person Picking Up Information: ☐ Driver's License #________________________ ☐ Other: ________________________ ID Verified by:________________________________	Account #:________________________ MRN:________________________ Date of Release:________________________

PLEASE PROVIDE A COPY TO THE PATIENT. ONE COPY SHOULD BE SENT WITH INFORMATION BEING DISCLOSED.

Patient's Name

Patient's Birthdate:

Phone Number: