AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

I hereby authorize PROVIDER OR CLASS OF PROVIDERS[4] to disclose the following protected health information:

TYPE OF INFORMATION TO BE DISCLOSED:

☐ Recollections of Patient Encounters [5] ☐ _____

☐ _____ ☐ _____

EACH PURPOSE FOR USE AND/OR DISCLOSURE:

☐ At Patient Request [6] ☐ _____

☐ _____ ☐ _____

RECIPIENT or CLASS of RECIPIENTS[7] OF PROTECTED HEALTH INFORMATION:

☐ Allow mutual exchange of information between Deborah J. Moran, M.S., and _____

(Name, Title, Group or Other Affiliation)

SPECIFIC AUTHORIZATION AS TO CERTAIN PHI: I am aware that my records may contain healthcare information relating to testing, diagnosis or treatment for HIV/Aids or for any other STD as governed by RCW 70.24 for chemical dependency as governed by RCW 70.96A and/or 42 CFT Part 2, and/or for mental health as governed by RCW 71.05 as to adults and by RCW 71.34 as to minors. I specifically authorize PROVIDER to disclose any and all such information, if not excluded by initialing below.

My initials constitute my intention to **exclude** from this Authorization healthcare information relating to testing, diagnosis or treatment for the corresponding conditions, illness or disease: _____ HIV/AIDS/STDS ____ Chemical Dependency ____ Mental Health

DELIVER BY: ☐ Mail/Courier/Fax at _____ ☐ In Person/Phone at _____

MY RIGHTS AND RISKS:

REVOCATION: I understand that I may revoke this authorization in writing at any time; that PROVIDER will make a Revocation Authorization form available to me; that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on the Authorization, including provision of health care services requiring subsequent disclosure to effect payment. I understand that DSHS certified drug and alcohol programs will honor verbal revocations, upon verifying authenticity.

RISK OF RE-DISCLOSURE: Re-disclosure of my health information by recipient, if unauthorized, is a potential risk. If re-disclosed, Privacy laws may no longer protect the information.[8]

REFUSAL TO SIGN: I understand that I do not have to sign this authorization in order to obtain treatment benefits from PROVIDER except for health care services necessary to create any assessment or report for disclosure to the recipient(s) identified in this authorization.[9]

RECEIPT OF A COPY: I understand I am entitled to receive a copy of any Authorization I sign.

DURATION: If not previously revoked, this authorization will expire: (Date, event, or condition) _____

SPECIFIC LIMITATION: The duration of this authorization may not exceed ninety (90) days from the date of last signature if the recipient is my employer or a financial institution, and the purpose is for other than payment.[10]

EFFECTIVE DATE: This authorization covers protected health information pertaining to: _____ _____ and is effective from date of signature.

_____ _____

Signature (Patient/Parent/Guardian/Other Personal Representative for health care decisions) Date

_____ _____

Signature (Patient/Parent/Guardian/Other Personal Representative for health care decisions) Date

[4]RCW 70.02.030 (2)(d)
[5]Wynn v. Earin Court of Appeals Div. III State of WA, Docket #22811-8-III December 22, 2005
[6]164.508(c)(1)(iv)
[7]RCW 70.02.030(2)(c)
[8]164.508(c)(2)(i)
[9]164.508(b)(4)(iii)
[10]RCW 70.02.030(6)