



AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

The undersigned patient authorizes EASTSIDE ADDICTION PROFESSIONALS to disclose/receive copies of the specified records as he/she has directed.

1. **RECORDS:** The following records are included in this request: (Requires Patient Initials)

_____ Identity, dates of attendance, diagnosis, prognosis, recommendations, treatment rendered, assessment, locations, progress, treatment status, dialogue with recipient, treatment summary and treatment coordination.

Other: (specify) _____ Identity and date of birth

2. **DISCLOSE / RECEIVE** specified records to/from the following:

Organization: _____ Sterling Reference Laboratories

Name/Title and/or individual: _____ Sterling Reference Laboratories Staff

Mailing Address: _____ 624 Martin Luther King Jr. Way

City: _____ Tacoma State: _____ WA Zip: _____ 98405 Phone: _____ 800-442-0438

3. **PURPOSE:** At patient's request:

Status Report: Counseling/Therapeutic Value: Court/Litigation related: _____

Other (specify): _____ Urinalysis

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable disease, including sexually transmitted disease (e.g., Tuberculosis, HIV/AIDS related illness), mental health services, drug and/or alcohol services. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. Including provision of healthcare service requiring subsequent disclosure to effect payment. Unauthorized re-disclosure by recipient is prohibited, but may be a potential risk. I understand that generally the alcohol and/or drug treatment program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstance I may be denied treatment if I do not sign a consent form. In any event this authorization expires automatically as follows:
1 (one) year from date of signature. _____

SIGNATURES:

Printed Name: _____ Date of Birth _____ SS# _____

Signature _____ Date _____

I am the patient's parent or legal representative for healthcare decisions.

Printed Name _____ Relationship to patient _____

Signature _____ Date _____

Witness _____ Date _____

Delivery Instructions:

Mail/Courier: _____

Telephone: _____

Other: _____ Fax: 253-552-1549