Elite Performance And Therapy

284 Central Way | Kirkland, WA. | 98033 | P (425) 999-4484 | F (425) 605-1288

Patient Health Information Authorization of Release

Patient Name: ________________________________ Date of Birth: ________________________

Contact Number(s): ______________________________ ______________________________

I authorize the following organization to release information as stated below from the patient health record:

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASE TO:
☐ Elite Performance And Therapy or:	☐ Elite Performance And Therapy or:
☐ ______________________________	☐ ______________________________
Organization and/or person	Organization and/or person
______________________________	______________________________
Street address City, State, Zip	Street address City, State, Zip
______________________________	______________________________
Phone # Fax #	Phone # Fax #

☐ *I authorize ongoing communications between the above listed parties.*

INFORMATION TO BE RELEASED

☐ Health records ☐ Billing records ☐ All records

☐ Specific records/dates: ______________________________ Form of records: ☐ Paper ☐ CD

PURPOSE OF RELEASE

☐ Legal ☐ Personal use ☐ Cont. care ☐ Transferring ☐ School

☐ Other: ____________________ ☐ Reason: ______________________________

If the person or entity receiving the above records is not a healthcare plan and/or provider covered under federal privacy regulations, the above records may be re-disclosed and are no longer protected by said regulations. Additionally, a recipient(s) may be prohibited from disclosing any substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

The person I have given authorization to use and/or disclosure said records may receive compensation for doing so.

I have the right to refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, and/or my eligibility for benefits. I may inspect or copy said records to be used and/or disclosed under this authorization. Authorization may be revoked at any time, except to the extent which this action has been taken in reliance on the authorization.

Revocation of authorization must be submitted to 284 Central Way, Kirkland, WA. 98034.

This authorization will expire on ____________________ (date or event, if applicable).

Authorized Signature: ______________________________ Date: ______________________