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Release of Confidential Health Information

Client Name: _____ DOB:_____

I, _____hereby give permission for Confidential Healthcare Information to be:

☐ Exchanged
☐ Provided
☐ Obtained

From/With the following recipient(s):

Name of Person/Business:_____

Address: _____

Phone Number :(____) _____

Purpose of Disclosure: _____

Special Permissions:

****I give permission to disclose the following records (check all that apply):**

- ☐ HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.24.105)
- ☐ Mental Health Records (RCW 71.05.630)
- ☐ Chemical Dependency (CD) records (42 CFR Part 2)

This disclosure is valid for one year (365 days) from the date that it is signed. The patient reserves the right to revoke this release at any time. By signing below, you understand and agree to these terms when providing healthcare information to the participating providers.

Client/Legal Representative Signature: _____Date: _____

Witness: _____Date: _____