EXCELSIOR
WELLNESS CENTER

3754 West Indian Trail Road
Spokane, WA 99208-4736
T: (509) 559-3100 F: (509) 328-7582

## AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, (individual receiving services)_____ (DOB)_____ hereby authorize an exchange of information between Excelsior Youth Center and _____
(Organization/Individual)

_____.
(Address, Telephone, Fax)

**I release the following information:** (check all that apply)

- ☐ Identity
- ☐ Dates of Service
- ☐ Progress Reports
- ☐ Assessment/ Diagnosis
- ☐ Legal Records
- ☐ Mental Health Records
- ☐ Physical Health Records
- ☐ Drug and Alcohol Records
- ☐ Discharge Summary
- ☐ General Progress/Condition
- ☐ Urinalysis/Breathalyzer Results
- ☐ Other _____

**The purpose or need for the exchange and disclosure of this information is to:** (check all that apply)

- ☐ Facilitate Treatment
- ☐ Summarize Treatment
- ☐ Coordinate Continuing Care
- ☐ Other_____
- ☐ Legal

**This information may be released or exchanged via:** (check all that apply)

- ☐ In Person
- ☐ Telephone
- ☐ Mail/Courier
- ☐ Facsimile (Fax)
- ☐ Electronic Mail

I understand that my records are protected under federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2 and the Health Insurance Portability Act of 1996 (HIPAA), 45 CFR pts 160 and 164. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases (e.g., Tuberculosis, HIV/AIDS), mental health services, drug and/or alcohol services. I understand that my records cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke this consent at any time unless action has been taken in reliance on it. I understand that information used or disclosed under this authorization has the potential of being re-disclosed by another party and thereby no longer protected. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain enrollment, treatment, or payment unless otherwise required or indicated in the provision of quality care. This authorization expires on: _____(If no date or event is identified, the authorization will terminate 60 days after the last treatment or evaluation session I attend.)

_____/_____ _____/_____/_____
Individual (Print name) Signature Date

_____/_____ _____/_____/_____
Parent/Guardian (Print name) Signature Date

_____/_____ _____/_____/_____
Excelsior Representative (Print name) Signature Date