TIDEPOOL MENTAL HEALTH
Where change happens.

Tidepool Mental Health PLLC
210 Polk Street Ste 10
Port Townsend, WA 98368
Phone: (360)928-6649
Fax: (920)605-8991

Authorization for use or disclosure of protected patient health information:
Note: Fees may apply to certain requests

See reverse side for instructions to fill out this form.
Failure to follow instructions may result in processing delay.

1. PATIENT INFORMATION
PRINT Patient Name: _____
Birth Date (mm/dd/yyyy): _____

Address: _____
City: _____ State: ____ Zip: _____
Phone #: _____
Email: _____

2. TIDEPOOL MENTAL HEALTH CAN ❑OBTAIN INFORMATION FROM: ❑DISCLOSE INFORMATION TO:

Organization or person: _____
Address: _____
City: _____ State: _____Zip: _____
Phone: _____Fax _____
Email: _____

METHOD FOR RECORDS DISCLOSURE: ❑Verbal Communication ❑Secure Email ❑Fax ❑Patient Portal

3. PURPOSE OF RELEASE: ❑Continuing Care ❑Medical Leave ❑Legal ❑Personal / Other

4. INFORMATION TO BE RELEASED: From Date: ____/____/____ To Date: ____/____/____

❑ Medical Records
❑ Psychiatric Evaluations
❑ Progress Notes
❑ Other: _____
❑Medication Management
❑Treatment Plans
❑Discharge Summaries
❑Labs

I specifically authorize the disclosure of: ❑ Substance Use Disorder Records ❑Psychotherapy Notes

❑HIV/AIDS-related information ❑Genetic Testing ❑Sexual/reproductive health ❑ History of Abuse or Trauma

5. PATIENT AUTHORIZATION. I understand that:
In addition to Behavioral Health information, I may specifically authorize the disclosure of information related to HIV/AIDS, substance use disorder and treatment, information regarding abuse and trauma, genetic testing, sexually transmitted disease, and if under the age of 18, reproductive care. By signing this form and checking the associated boxes above, I give my specific authorization for this information to be released.

- I understand this authorization is voluntary.
- Generally, an entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment, not signing or revoking this authorization may impact enrollment or benefit determinations.
- Once disclosed, health care information may be subject to redisclosure by the recipient and may no longer be protected under health information privacy laws, except where prohibited such as SUD records.
- I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.

6. SIGNATURE_____DATE:_____
If personal representative, print name and relationship: _____
*Documentation may be required to prove authority to sign on behalf of the patient.

7. MINOR SIGNATURE:_____DATE:_____
Signature of minor (ages 13 - 17) is required for certain information, **see number 7 on instruction page**.

8. This authorization expires one year from the date signed OR on the date indicated here:_____

INSTRUCTIONS:

1. **PATIENT INFORMATION:** Print name of patient, birth date, address, phone number and email.
2. **RECIPIENT INFORMATION: Check if consent is to obtain information from OR disclose information to. (May include verbal communication)**
   Print name, address, phone number, fax number and email address.
   Delivery method: Please PRINT the email address clearly
3. **PURPOSE:** Check the box that applies to the reason the records are being requested.
4. **INFORMATION TO BE RELEASED:** Indicate date(s) that are authorized to be released.
   - Medical records – a maximum of 10 years of records
   - Other – use this field to indicate specific information needed. Only that specific information will be released.
   - Indicate the type of information to be released.
5. Read the **PATIENT AUTHORIZATION section.**
6. **SIGNATURE:** Sign and date. Electronic signatures must meet federal and state requirements. Personal representative should print name and indicate relationship to the patient. Documentation may be required to prove authority to sign on behalf of the patient.
7. **MINOR SIGNATURE:** Minor patients have the right to control certain types of healthcare information. They may be required to sign an authorization to release this information.
   - Sexually transmitted diseases including HIV (ages 14-17)
   - Mental health and addiction recovery services (ages 13-17)
   - Reproductive care (all minors)
8. **EXPIRATION:** If no date or event is given, authorization will expire one year from date signed.

To submit your request, please send your completed form to the appropriate location listed below. Fax submission is preferred. Please visit our website at https://www.tidepoolmentalhealth.com for additional copies of this form or call for more information.

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Release of Information
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