Authorization for Release of Information

Patient Name: _____ Birth Date: _____

Address: _____, _____, _____

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

Information may be released verbally or in writing for the purpose of treatment planning, assessment and/or referral. I also authorize the release of my personal health information sufficient to file a claim with my health insurance company.

I understand that I may revoke this authorization at any time by notifying Douglas W. Benjamin, M.S., LMHC in writing, but if I do, it will not have any effect on any actions Douglas W. Benjamin, M.S., LMHC took before receiving the revocation.

I understand this release expires 90 days after signed, including authorization to release future health care information, except information to third party health care payers.

I hereby authorize Douglas W. Benjamin, PhD, MS, LMHC to exchange, release and/or obtain my personal health information with the parties I have indicated below:

Name /Organization: _____

Address: _____, _____, _____

Phone: ___ - ___ - _____ Fax: ___ - ___ - _____

Name /Organization: _____

Address: _____, _____, _____

Phone: ___ - ___ - _____ Fax: ___ - ___ - _____

_____ _____

Signature of Patient/Legal Guardian or Representative **Date**

_____ _____

Signature of Witness **Date**

Douglas W. Benjamin, M.S., LMHC--PO Box 28262 Bellingham, WA 98228 Ph:(360) 671-8330 Fx:(360) 733-2219 doug@dougbenjamin.net