TriCities Family Health
2630 N. Columbia Center Blvd.
Richland, WA 99352

Consent for Release of Information

Patient Name: ______________________________ DOB: ______________________

I, ____of ____________________________
(Print Name) (County)

authorize, Zain Medical Center (TriCities Family Health), to disclose to and/or receive information from:

Agency/Person(s) Name ____

Address ____

City, State, Zip code ____

Telephone Number _________________________ Fax Number ______________________

Email Address ____

I understand that the purpose of this release is to allow Zain Medical Center (TriCities Family Health) to exchange information about me in any form including verbal, written and electronic with the above named entity in order to facilitate appropriate treatment and medical care. I also understand that if I decline to sign this or any additional requested releases that I am not eligible to participate in Zain Medical Center (TriCities Family Health).

Types of information that may be shared include, but are not limited to:

- Substance use history
- Diagnostic impression, symptomology and treatment recommendations or services
- Medical and/or psychiatric conditions
- Prescribed medications
- Results of urine, blood, hair, etc. testing

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent. I may revoke this consent at any time. Unless revoked, this authorization expires in 90 days or on this date: __________________

Patient Signature _______________________________________ Date ___________________