CENTER for SOLACE
BEHAVIORAL HEALTH SERVICES
407 E 2ND AVE SUITE 250 | SPOKANE WA 99202 | (509) 315-9776

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, _____(client), DOB _____

Address: _____

Phone: _____ _____ Email: _____

Authorize Center for Solace PLLC to Disclose the PHI as described below.

Center for Solace is authorized to disclose/exchange information to/with (Person or Business):

_____

Name of person or Business **Email Address**

_____

Address **City**

_____

State **Zip**

Description of Information to be disclosed:

- ☐ All health-related information with no restrictions
- ☐ Intake assessment
- ☐ Intake assessment, treatment plan, diagnosis
- ☐ Substance Use Disorder
- ☐ Other: _____
- ☐ Progress notes
- ☐ Mental Health Diagnosis
- ☐ HIV/AIDS
- ☐ Psychiatric Diagnosis
- ☐ Dates of Service for Payment
- ☐ Medical Diagnosis
- ☐ STDs

Purpose for disclosed information:

- ☐ Coordinate Billing and Payment
- ☐ Record Request
- ☐ Custody Determination
- ☐ Client Request
- ☐ Coordination of Care
- ☐ Continuity of Care
- ☐ Legal Matters
- ☐ Other _____

This release is valid until:

- ☐ Upon Execution
- ☐ 90 days
- ☐ One Year
- ☐ Date / Event: _____

I understand and acknowledge that I may refuse to sign this authorization and this will not condition treatment on whether the authorization is signed unless the authorization is for the use or disclosure of information for research related treatment, or unless treatment is solely for the purpose of disclosing information to a third party. A person may revoke this authorization at any time unless action has been taken in reliance on the authorization. To revoke the authorization, one must submit a written request. Information disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by applicable law. This authorization will automatically expire one year from the date it is signed if not earlier in adherence to the signatory's identified completion date.

Client's Printed Name: _____ Signature: _____ Date:_____