Briar Rose Center: The Home of Hope & Healing, P.L.L.C.
Kimberly L. Cole, Psy.D.

11802 E. Mansfield, Suite 1
Spokane Valley, WA 99206

Phone: (509) 473-9157 Fax: (509) 343-1622
drkimberlycole@briarrosecenter.com www.briarrosecenter.com

Authorization to Release Medical Information

Patient's Name: _____

Birth Date: _____

REQUESTING RECORDS FROM: _____

RELEASE/SEND RECORDS TO: BRIAR ROSE CENTER: THE HOME OF HOPE AND HEALING, PLLC
DR. KIMBERLY COLE
11802 E. Mansfield
Suite 1
Spokane Valley, WA 99206
FAX: (509) 343-1622

Information to be released:
( ) The most recent 2 years of pertinent information (chart notes, testing, medications)
(X) All medical records
( ) Specific Information (**Please specify)** _____

Purpose for which disclosure is being made: (Please check one of the following):

[ ] Attorney [ ] Insurance [X] Doctor [ ] Personal [X] Treatment [ ] Other _____

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial):
___Drug/Alcohol abuse/treatment & diagnosis ___Sexually Transmitted Disease
___Mental Illness or Psychiatric diagnosis/treatment____HIV/AIDS diagnosis/treatment/testing

MY RIGHTS
I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed in this authorization. There may be a charge for these copies.

This authorization will automatically expire one year from the date signed or until the 3rd party payor claim settled. I understand that I may revoke this authorization at anytime except to the extent that action has been taken in reliance thereon. To revoke this authorization, I must submit my request in writing to Dr. Kimberly Cole.

SIGNATURE:_____DATE: _____
(Client, Guardian, or Authorized Representative)