Authorization for Release of Health Care Information and Records

Patient Name ____ Date of Birth: ________________
(First / MI / Last)

Information to be released FROM:	Information to be released TO:
☐ Sound Sleep Health **OR**	☐ ____________________________________ (Organization / Person)
☐ ____________________________________ (Organization / Person)	____________________________________ (Street Address)
____________________________________ (Street Address)	____________________________________ (City, State, Zip)
____________________________________ (City, State, Zip)	____________________________________ (Telephone / Fax #)
____________________________________ (Telephone / Fax #)	☐ Sound Sleep Health 13531 Juanita Woodinville Way NE Kirkland WA 98034 Phone: (425) 636-2400 Fax: (425) 636-2401

Types of Information to be released:
I permit Sound Sleep Health, herein referred to as "Provider," to release the following health care information to the Provider listed above. I understand that the Provider needs my written authorization to release any health care information about testing, diagnosis, procedures and/or treatment for alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS) or psychiatric disorders/mental illness. Based on the box(es) I have checked below, the Provider may release all diagnostic, treatment information and records, except psychotherapy notes as defined by the Health Insurance Portability and Accountability Act of 1996, which requires a separate authorization.

- □ General Health Care
- □ Alcohol and/or Chemical Dependency
- □ Reproductive Health (including Abortion)
- □ Sexually Transmitted Diseases (HIV/AIDS)
- □ Psychiatric Disorders/Mental Illness
- □ Other: ________________________

Purpose for release and how information will be used:
□ At the request of the individual
□ For coordination of care
□ Other (please state specific date, specific time period, event or condition): ____________________________

Timeframe of Release: Unless I revoke it, this release will remain valid for ninety (90) days from the date of my signature below.

Signature: ___________________________ Print Name: ___________________________ Date: ___________

If not the patient, I am the: □ Parent □ Legal Guardian □ Holder of Power of Attorney
If you are the legal guardian or holder of a power of attorney for the patient, attach legal documentation.

Revocation of Release: I understand that I may change my mind and revoke this at any time. I will do this by letting the Provider know of my decision. Any change will be effective five (5) business days after the Provider receives my written notice. I understand that some or all of this information may already have been shared and the Provider will not be liable for any information already released.

Redisclosure: Information disclosed as a result of this authorization may be redisclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules.

No conditions: This authorization is voluntary. We will not condition your receipt of treatment on giving this authorization. Please keep a copy of this release for your records.