The Charis Clinic PLLC dba Charis Family Clinic
23601 Hwy 99 Ste A
Edmonds, WA 98026
206-714-4476

AUTHORIZATION TO DISCLOSE/RELEASE PROTECTED HEALTH INFORMATION

- **I hereby authorize the release of protected health information (PHI) contained in my medical record to me, or to the party listed below. I understand that information released from The Charis Clinic PLLC is its property, and that a fee may be charged for the copying of any medical records.**
- **I understand that the information I am authorizing for disclosure/release to The Charis Clinic PLLC may be subject to re-disclosure and no longer be protected by the privacy rule.**
- **I understand that I have the right to withdraw this authorization at anytime, except for action already taken, and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation, will automatically expire 90 days from the date of my signature.**

Patient:
Name ____
Former Name ____
Address, City, State ____
Date of Birth ____________________ Date(s) of Service ______________________

Individual or Institution Protected Health Information is to be Released FROM:
Name ____
Address____
Phone Number ____
Fax Number ____

Individual or Institution Protected Health Information is to be Released TO:
Name ___________________________ or Check if applicable: ☐ **Charis Family Clinic**
Address____________________________ 23601 Hwy 99, Ste A, Edmonds, WA 98026
Phone Number ______________________ (PH) 206-714-4476
Fax Number ________________________ (Fax) 425-732-4476
Purpose for Disclosure/Reason for Request: _______________________
Protected health information may include medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital records, clinician office chart reports, laboratory reports, dental records, pathology reports, therapy reports, hospital records, and other personal information.
Information to be Released: ☐ **Entire medical record**
☐ Medical record from the following date___________ to the following date ____________
Specific information: ___________________

I understand that my Provider needs my specific authorization to release information pertaining to the items listed below. By initialing each of the listed items, I authorize release of the information pertinent to my case:
☐ Sexually Transmitted Diseases, including HIV/AIDS diagnosis/treatment __________ (initial)
☐ Chemical Dependency (Alcohol/drug diagnoses/treatment) __________ (initial)
☐ Mental Health Information (Psychological diagnoses/treatment) __________ (initial)
☐ Reproductive Health Information (including abortion) __________ (initial)
☐ Records received from other specialists __________ (initial)

Redisclosure: Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of the Alcohol and Drug Abuse records which are protected by Federal Confidentiality Rules (42 CFR Part2). The Federal Rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part2.
I understand that The Charis Clinic PLLC cannot require me to sign this authorization in order to receive Health Care treatment, to enroll, or be eligible for benefits.

_____________________________________ _______________
Signature of Patient or Legal Representative (mark below if legal rep) **Date**
☐ **Parent** ☐**Legal Guardian** ☐ **Holder of Power of Attorney**