The Charis Clinic PLLC dba Charis Family Clinic
7631 212th St SW Ste 101A
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 any time, and that such revocation must be in writing. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Further, I understand that this authorization, without prior revocation, will automatically expire 90 days from the date of my signature unless I have stated otherwise.**
- **I understand that treatment will not be conditioned on signing the authorization (except treatment may be conditioned upon the individual signing an authorization when the treatment is related to research, or the treatment is provided for the purpose of disclosure to a third party—for example an independent medical examination).**

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_____ 7631 212th St SW Ste 101A, 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 **Specific information: _____**
☐ Medical record from the following date_____ to the following date _____

I understand that my Provider needs my specific authorization to release information pertaining to the items listed below. I specifically authorize release of sexually transmitted diseases, including HIV/AIDs, chemical dependency, mental health information, reproductive health information, and records from other specialists unless I have indicated below that I do NOT want disclosure of one of these below:

Do NOT disclose:
☐ 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