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Charles R. Wang, M.D.
Child, Adolescent & Adult Psychiatry

Elizabeth J. Wasson, Ph.D.
Child & Adult Clinical Psychology

Delton W. Young, Ph.D.
Forensic & Clinical Psychology

Authorization to Use or Disclose My Protected Health Information (PHI)

Patient name: ______________________________ Date of birth: ______________

Persons or Class of Persons Authorized to Make the Use or Disclosure of Authorized Information:

Name (or title) and organization: ______________________________ Phone: ____________

Address: ______________________________ City: ____________ State: ______ Zip: ____

You may disclose this Protected Health Information to:

Name (or title) and organization: ______________________________ Phone: ____________

Address: ______________________________ City: ____________ State: ______ Zip: ____

You may use or disclose the following Protected Health Information (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: __________
- ☐ Health care information in my medical record for the date(s): ______________________________
- ☐ Other (e.g., X rays, bills), specify date(s): ______________________________
- ☐ Mutual Exchange of Information

My Rights

▪I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS or HIV infection, alcohol and/or drug abuse and mental health conditions.

MINORS: *A minor patient's signature is required in order to release the following information: 1. alcohol and/or drug abuse and mental health conditions (age 13 and older); 2. sexually transmitted diseases, including HIV/AIDS (age 14 and older).*

▪I understand that this authorization will expire in 90 days; unless otherwise specified herein: ____________________

▪I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

▪I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Interlake Psychiatric Associates, PLLC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Interlake Psychiatric Associates, PLLC; OR
- Write a letter to: Privacy Office, Interlake Psychiatric Associates, PLLC
  2025 112th Avenue NE, Suite 200, Bellevue, WA 98004.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

______________________________ ______________________________
Patient or legally authorized individual signature Date

______________________________ ______________________________
Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)