315 Lakeway Dr. Bellingham, WA 98225
Tel: (360) 329-2055 Fax: (360) 329-2055 Web: EmergeClinic.com/records Email: records@emergeclinic.com

Patient Authorization to Disclose Protected Mental Health Information (ROI)

Patient Information (*required):

Name (Last, First, MI) *	
Date of Birth *	Phone Number *

Purpose for disclosure – may be released electronically. (Check all that apply)

☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify) _____

Records to be disclosed to (* required):

Name – (e.g. Insurance Company, Attorney, Physician, Patient) *			
Email *	Tele # *	Fax #	
Street Address	City	State	Zip

I hereby authorize the release of the following records:

☐ Initial box if you would only like specific information or specific dates of service released and not the entire mental health record. Specify information to be released:
_____ from _____/_____/_____ to _____/_____/_____.

☐ Initial box to release a complete copy of your mental health record.

This authorization is in effect until one year from the date it is signed by the patient, OR until date : _____/_____/_____

This authorization form can be sent to us by mail or fax. If the patient chooses to accept the risks associated with unencrypted email (that email communications could potentially be read by a third party), the form may be sent by email.

Minors: A minor patient's signature is required to release the following information: (1) conditions relating to the minor's reproductive care (2) sexually transmitted diseases *(if age 14 or older),* (3) alcohol and/or drug abuse and mental health conditions *(if age 13 and older).*

Patient Rights: I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment, or enrollment). I may revoke the authorization at any time except to the extent already relied upon by sending a request in writing to Emerge Clinic, LLC, 21 Bellwether Way, Suite 107, Bellingham, WA 98225. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws. I understand Emerge Clinic, LLC will not base treatment or payment decisions on receipt of this signed authorization. I also understand I have the following rights to, (i) Inspect or receive a copy of my protected health information, (ii) Receive a copy of this signed form, (iii) Refuse to sign this form for authorization to disclose or release my protected health information.

By signing this page, I acknowledge that I have read and agreed to the terms on this form (* required)

Signature (Patient or Person Authorized) *	Date *
If Signed by Person Other Than Patient, Provide Their Authority *	