MindHealth Associates
Erika Giraldo & Leif Benjestorf

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Phone Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with Washington State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT** and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION ALLOWS YOU TO DISCUSS MY HEALTH INFORMATION AND MEDICAL CARE WITH ERIKA GIRALDO AND/OR LEIF BENJESTORF FOR THE COORDINATION OF CARE.

7. Exchange Information With:
Name: Address: Fax:

8. Send Information To/Receive Information From:
Name: Erika Giraldo, DNP/Leif Benjestorf, ARNP Address: 19109 36th Ave W, Lynnwood WA 98036 Fax: (425) 673-7586

9(a). Specific information to be released:(Indicate by Checking box)

□ Medical Record from (insert date) ______________________to (insert date)______________________

□ Entire Medical Record. May include patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

□ Other:____________________________________

Include: (*Indicate by Initialing*)

_______ **Mental Health Psychotherapy Notes**
_______ **Mental Health Information**
_______ **Alcohol/Drug Treatment**
_______ **HIV-Related Information**
_______ **Genetic Testing**

10. Reason for release of information: □ At request of individual □ Other:	11. Date or event on which this authorization will expire: _______ **End Of Service Or Date:**______________ Initials
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

____ Date: ____________________________________
Signature of Patient or representative authorized by law.