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Ph: (425) 919-6826
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# AUTHORIZATION FOR RELEASE OF INFORMATION

**Patient Name** _____ **Date of Birth** _____

**Home Address** _____

*If applicable:*
Legally Authorized Representative/Guardian Name _____

_____ _____
Legally Authorized Representative/Guardian Signature Today's Date

**I, _____, hereby authorize**
**Eastside TMS & Wellness Center, PLLC, to receive from and release to:**

Name of Person/Clinic/Entity
Address _____
Telephone
Fax _____
Secure email address

**I understand that this authorization extends to the following confidential information/records:**

- ☐ Medical
- ☐ Psychiatric
- ☐ Intake/Discharge
- ☐ Chemical Dependency
- ☐ Psychological Testing
- ☐ Therapy Notes
- ☐ Lab Tests
- ☐ Any other clinically relevant records

**I authorize Eastside TMS & Wellness Center to:**

- ☐ Talk with the provider
- ☐ Release all relevant healthcare information in my medical record

*If the ROI is addressed to a school/educator, I understand that the purpose of this request is to assist in planning an appropriate educational program for my child and that no other party except authorized school personnel shall have access to this information.*

**Please send all relevant information to the contact information listed above.**

## HIPAA Compliance

Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to coordinate healthcare, to seek insurance payment, and/or to perform other specific healthcare procedures/services consented to by the patient.

1. I understand that I do have to sign this authorization to get healthcare benefits. However, I do have to sign an authorization form to receive healthcare when the purpose is to create healthcare information for a third party.
2. I understand that if I revoked this authorization, it would not affect any actions already taken by Eastside TMS & Wellness Center, PLLC, based upon this authorization, prior to it being revoked.
3. This authorization expires in: ☐ 90 DAYS ☐ 180 DAYS ☐ END OF TREATMENT
4. I understand that I can revoke this authorization at any time in writing.