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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/Entitv _____
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.

The material in this facsimile/letter is intended for the use of the individual to whom it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. If you are not the intended, please be advised that the unauthorized use, disclosure, copying, distribution or the taking of any action in reliance on this information is strictly prohibited. If you have received this facsimile in error, please notify us immediately at the phone number listed below.

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.

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