C.A.R.E Alliance NW, Inc.
Marycliff Professional Center.
703 West 7th Avenue, Suite L-20. Spokane, WA. 99204
Phone: (509) 496-3143 Email: Neasterling@carealliancenw.com

Authorization for Use or Release of Information

Updated 1/2014 HIPPA-HIV-Mental Health & Substance Abuse Compliant

I hereby authorize Person/Entity Name Nikki R. Easterling, M.Ed, CDP, CC [ ] C.A.R.E. Alliance NW, Inc Nikki Easterling, MEd, CDP, CC

Address Marycliff Center Undercliff House 703 West 7th Ave Ste L-20 Spokane, WA 99204

Telephone PH (509) 496-3143 Fax (509) 267-678

to release health information and records for: **Patient Name**:_____ Date of Birth:_____

Address _____

The information is to be used or disclosed to the following persons or organizations:

Person/Entity Name: Address: _____

Phone: _____

The purpose of the use or disclosure is: [ ] At the request of the patient [ ] Continuity of care [ ]Other _____

Information to be used or disclosed includes only those items checked below with respect to services provided on or around (insert dates of service) :_____.

If this line is left blank, the treatment dates covered by this authorization are the date of intake to the last date of service.

I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for behavioral health, alcohol/drug abuse, HIV/AIDS test results or diagnose. The information to be used or released includes:

[ ] Intake information	[ ] Treatment plans	[ ] Psychological testing
[ ] Progress notes	[ ] Billing/Financial records	[ ] Collateral communication
[ ] Maternity care	[ ] Medical records	[ ] Other:

This authorization is limited to only that information that I have requested above to be used or disclosed to the persons/facilities named herein. I hereby release C.A.R.E Alliance NW, Inc.and its employees from all legal responsibilities or liability that may arise from the use or disclosure of medical records and other health information in reliance on this authorization.

C.A.R.E. Alliance NW, Inc will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

1. **Expiration**: I understand that unless I revoke this authorization earlier, this authorization will automatically expire 180 days, or according to the relevant state or federal law, from the date this authorization is signed.
2. **Re-Disclosure**: I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
3. **Refusal to sign**: I understand that I may refuse to sign this authorization and that C.A.R.E Alliance NW, Inc. will not condition treatment on whether I sign this authorization.
4. **Certification**: I certify that I am (check whichever applies):
   [ ] The patient, and the identification that I have provided is true and correct.
   [ ] The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. "My relationship to the patient is that of: _____".
5. **Revocation**: I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization
6. **Copy**: I understand that I will receive a copy of this completed form upon request.

_____ _____ _____ _____

Date (Patient Signature – 12 or older) (Parent/Guardian - Under 12) (Date)

_____ _____ _____

Date (Staff Member/Witness) (Printed Last Name)

I have received _____ as documentation that verifies the relationship with the patient and the authority to receive health information on behalf of the patient.

_____ _____ _____

Date (Staff Member/Witness) Printed Last Name

FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (Prohibition on Redisclosure, 2004)