CARITAS
CriticalCaseManagement

Receive Records

Authorization to Use and Disclose Protected Health Information

Patient's Full Name | Social Security Number/Medical Record Number

Address | City, State, Zip Code

Date of Birth | Date(s) of Service

I hereby authorize the use or disclosure of protected health information about me as described below:

Name and address of health care provider/facility:

Disclose Protected Information to:

Ebony Blackmon Humphrey, DNP ARNP
PMHNP-BC CCM CNE
Psychiatric Mental Health NP
8201 164th Ave NE #200
Redmond, WA 98052
Fax Documents to 855.930.1412

By initiating below, I specially authorize the disclosure of the following information and/or records:

Healthcare information relating to the following treatment, condition or dates:

All healthcare information.

Other:

I understand that my express consent is required to release any health care information relating to testing, diagnosing and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, drug, and/or alcohol use, and genetic testing. By initialing below, I specially authorize the disclosure of then following information and/ or records:

☐ HIV/AIDS, Sexually transmitted

☐ Drug/alcohol, diagnosis and treatment

☐ Psychiatric disorders or mental health

☐ Genetic Testing

By my signature below I acknowledge that I may revoke this authorization in writing pursuant to the Privacy Notice to Patients posted at the facility where the information is to be released. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Furthermore, I understand that a copy of this authorization has the same validity as the original and that unless revoked earlier, this authorization will expire **1 year** from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____

Patient Signature | Date Signed

_____

Print Name