We Care DAILY CLINICS

PATIENT FULL NAME: _____

PATIENT BIRTHDATE: _____

PATIENT PHONE #: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize:

_____
(Name of Provider or Facility with information)

_____
(Address)

_____
(Phone Number)

_____
(Fax Number)

To exchange health information with:

We Care Daily Clinics
(Name of Provider or Facility receiving health information)
3320 Auburn Way N, Auburn WA 98002
(Address)
253-999-5750
(Phone Number)
253-999-5740
(Fax Number)

The purpose of this release is for (check one or more):

☒Continuity of care ☐Transfer ☒Communication with Care Team ☐Billing ☐Other (Specify):

We request the following records be sent to We Care Daily Clinics:

☒OUD Treatment Summary including authorizations below
☒Hospital H&P and Discharge Summary _____
☒Medication List
☒Immunization History
☒Problem List
☐Last three progress notes
☒Test results: ___all tests from hospitalization __
☐None; establishing two-way release of information

Specify the health information you authorize to be exchanged today and in the future until date below:

☒Initial Screening
☒Diagnoses and Problem List
☒Biopsychosocial Assessment
☒Treatment Recommendations
☒Medical records
☒Test results
☒Recovery Plan and Progress
☒Treatment Recommendations and Referrals
☒Dosing History
☒Face Sheet and Copy of ID
☐Other:_____

The following information will not be released unless specifically marked:

☒Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
☒Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, et *seq.*)
☒Release of HIV/AIDS test results (Health and Safety Code §120980(g)).
☐Release of genetic testing information (Health and Safety Code §124980(j)).

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of signing this form.

_____
Print Name

_____
Signature (Patient, Parent, Guardian)

_____
Date Time

_____
Relationship to Patient (Parent, Guardian, Conservator, Patient Representative)

Requested format: ☒Written ☒Verbal

NOTICE

We Care Daily Clinics (WCDC) and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Return Completed Authorization To:

Mailing Address **We Care Daily Clinics** 3320 Auburn Way N. Auburn WA. 98002	or	FAX Number: (253) 999-5740 Or via secure email at: hello@wecaredailyclinics.com

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative and delivered to Health Information Management Services. The revocation will take effect when WCDC receives it, except to the extent WCDC or others have already relied on it.

You are entitled to receive a copy of this Authorization.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.