CONSENT TO RELEASE AND OBTAIN INFORMATION – Page 1

This consent form is designed to allow us to exchange information with other health care providers involved in the client's care. This will allow us to either obtain relevant records to help us provide thorough and complete care to the client and/or allow us to share records with other providers in order to coordinate care. Please fill out one form per provider for whom you would like us to share information.

CLIENT INFORMATION:

Client's Name: _____ DOB: _____ Telephone #: _____
Address: _____

Services Pursued at UW Autism Center: _____

AUTHORIZATION FOR THE UW AUTISM CENTER TO DISCLOSE PROTECTED HEALTH INFORMATION

POTENTIAL FOR REDISCLOSURE: Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information.

REVOCATION: I understand that I may revoke this authorization by submitting the revocation request in writing to the UW Autism Center Privacy Office, Box 357920, Seattle, WA 98195, at any time. Any revocation will not be effective to the extent that action has already been taken based on the original authorization, or where the UW Autism Center requires the information in order to be paid for treatment provided to me.

I understand that I have the following rights: a) To inspect or to receive a copy of my protected health information, b) To receive a copy of this signed authorization and c) To refuse to sign this authorization.

I also understand that the UW Autism Center or a requesting covered entity will not condition treatment or payment based on receipt of this signed authorization, except: (1) UW Autism Center may condition research-related treatment on provision of an authorization for the use or disclosure of my information for such research; **or** (2) UW Autism Center may condition health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party; for example, when a non-UW employer contracts with the UW Autism Center to conduct TB testing for purposes of employee health screening.

SIGNATURE:

By signing, I acknowledge that I have read and agree to all the conditions specified in this consent form. I acknowledge the permission I have given the UW Autism Center to release, obtain or exchange information with the specified providers.

_____

Printed Name Relationship to Client

_____

Signature (Parent/ Conservator) Date

_____

Signature of Client (if client 13 years or older) Date

CONSENT TO RELEASE AND OBTAIN INFORMATION – Page 2

Client's Name: _____

OUTSIDE PROVIDER
CONTACT INFORMATION

☐ May release information to and/or ☐ May receive information from

Name: _____ Job Title: _____

Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____ Email: _____

CONSENT TO RELEASE AND OBTAIN INFORMATION

The purpose of this disclosure is: ☐ Coordination of Care ☐ At Request of Client
☐ Other: _____

This Authorization Expires: ☐ One year from today (_____) ☐ Date: _____

Note: If no expiration date is listed above, this authorization is valid for one year from the date on which it is signed.

INFORMATION AUTHORIZED TO RELEASE:
This section specifies what information the UW Autism Center can give to the outside provider listed above

Information that can be disclosed to the above provider: (please check all boxes that may apply)

☐ Treatment Summary ☐ Progress Notes ☐ Psychological Testing

☐ Verbal Disclosure of Information ☐ Other: _____ ☐ Evaluation Report

I understand that the information in the client's health record may include sensitive information regarding medical history and behavioral or mental health services and treatment.

I give the UW Autism Center permission to release the above information to the outside provider in writing (via mail or email) or verbally. _____

Signature (Client/Parent/Conservator) Date

INFORMATION AUTHORIZED TO OBTAIN:
This section specifies what information the UW Autism Center can get from the specified provider

Information that can be obtained from the above provider: (please check all boxes that may apply)

☐ Treatment Summary ☐ Progress Notes ☐ Psychological Testing
☐ Verbal Disclosure of Information ☐ Other: _____ ☐ Evaluation Report

I understand that the information in the client's health record may include sensitive information regarding medical history and behavioral or mental health services and treatment.

I give the UW Autism Center permission to obtain the above information from the outside provider in writing (via mail or email) or verbally. _____

Signature (Client/Parent/Conservator) Date