Revolution Psychiatry and Addiction Treatment
Dr. Richard Repass, MD
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Phone: (425) 652-4812 FAX: (425) 818-3821

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: ___/___/___ Social Security Number: ___ - ___ - ___
Home Address: _____ City: _____ State: ___ Zip Code: _____
Home Phone: ( ) _____ - _____ Mobile Phone: ( ) _____ - _____ Email: _____

I hereby authorize Dr. Richard Repass to release/receive the following health information:

_____ Initial Evaluation/Assessment
_____ Medical History and Information
_____ Psychotherapy Notes
_____ Office Visit/Progress Notes
_____ Complete Medical Record
_____ Psychological Reports & Testing Results
_____ Laboratory Results/Reports
_____ Billing Records/Information
_____ Transfer/Discharge Summary
_____ Other: _____

Sensitive Records require specific authorization.
****Please INITIAL the following****
__ Mental Health
__ Drug and/or Alcohol History

Please release the requested information for these treatment dates: _____

[ ] Records to be released to: [ ] Records to be requested/received from:

Name: _____ Relationship: _____
Address: _____ Telephone: ( ) _____ - _____ Fax: ( ) _____ - _____

I acknowledge that I have the right to revoke this authorization in writing at any time by sending such written notification to the releasing person/agency. I understand that my revocation will not be effective to the extent that Dr. Repass/Revolution Psychiatric has already taken action in reliance of this authorization or if this authorization was obtained as a condition of, obtaining insurance coverage and the insurer has the legal right to contest the claim. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be required as indicated in the copy of the Notice of Privacy Practices of Dr. Repass/Revolution Psychiatric, that I have received and reviewed. I acknowledge that the authorized recipient may accomplish the re-disclosure of my protected health information and that Federal Privacy Rule will no longer protect it. I acknowledge and understand that I am waiving my right to confidentiality with respect to the information or records released pursuant to this consent and I hereby release Dr. Repass/Revolution Psychiatric and his/its staff from any and all liability arising from the release and disclosure of the information or records. A photocopy or fax of this authorization is as valid as the original. **Please note: This authorization will automatically expire one year from signing unless other date of expiration is specified here**: _____

I acknowledge that I have read this authorization for release of information in its entirety and I fully understand its terms and implications. I freely, voluntarily and without and coercion, agree with the terms and conditions contained in this authorization.

Patient's Name [PRINT]: _____ DOB: _____
Patient's Signature: _____ Date: _____