ROBLEY K. YEE PhD, MSW

Licensed Independent Clinical Social Worker
Individual and Relational Psychotherapy

Robley K Yee, Ph.D., LICSW

PO. Box 28415
Seattle, WA 98118
Fax or Phone: 206-725-6617

Authorization For Release of Health Information

Date:	I hereby request and authorize ***ROBLEY K. YEE, PH.D., LICSW*** to release my health information.

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Birth date: / /	Sex: ❑ M	❑ F
Street address:		Social Security no.:		Home phone no.: ( )	
City:	State:	Zip:		Cell Phone No:	

I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION *(CHECK ALL THAT APPLY)*

❑ All Health information in my medical records	❑ Health Information relating only the the following treatment or condition:	❑ Health Information only for the following dates:

SPECIFIC PATIENT AUTHORIZATION REQUIRED

The following Types of Information Require your Specific Authorization – Please initial Each to Request Release

HIV / AIDS: _____ Sexually transmitted disease: _____ Mental Health: _____ Drug / Alcohol Abuse: _____

MINORS – A minor's signature is required in order to release the following:

- Information relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (***age 14 and older***)
- Alcohol, drug abuse and/or mental health conditions (***age 13 and older***)

Minor Name (Printed)

Minor Signature:

PURPOSE FOR THE DISCLOSURE *(CHECK ALL THAT APPLY)*

❑ Legal Proceedings ❑ Insurance Benefits ❑ Patient Use ❑ Employment ❑ Other

DISCLOSE THIS INFORMATION TO THE FOLLOWING PERSON OR ORGANIZATION

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Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

AUTHORIZATION EXPIRATION DATE

Note: Autnorizations for employment or to a financial institution can only be effective for a maximum of 90 days from the date signed by you. *(Select an Option Below, as desired)*

❑ 90 Days from the date signed ❑ On the following date: ❑ When the following event occurs:

YOUR RIGHTS

- I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligitility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party.
- I may revoke this authorization in writing. If I do, it will not affect any actions already taken by those who have relied upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form (A form is available from me) or write a letter to me.
- Once health care inforamtion is disclosed, the person or organization that receives it may redisclose it. Privacy laws may no longer protect it.

Patient/Guardian signature *Date*

If signed by person other than patient, print Name of Authorized Person and relation to patient and authority to authorize: