Blue Mountain Neuropsychological Associates, PS (Blue Mountain Psychology)
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Disclosure Authorization
Release of Information

(Complete this form if you know that BMNA staff will need to communicate with the client's/patient's/examinee's family physician, transportation services, family members, or others involved in their care)

Client/Patient/Examinee Name: ___________________ **Today's Date:** ______
DOB: ______

I authorize Blue Mountain Neuropsychological Associates, PS to exchange (i.e., **release and/or receive**) my confidential medical/health information with the following entity or entities:

____
____

The following types of information will be disclosed:

__All available records
__Diagnoses
__Treatment plans
__Other (please describe): ____

This disclosure authorization will expire on: ___/___/_____
Additional information regarding expiration of this authorization: _________________________

Signature of Client/Patient/Examinee: __________________ **Date:** ___/___/_____

Signature of guardian (if applicable): __________________ **Date:** ___/___/_____

Staff signature: __________________ **Date:** ___/___/_____

Disclosures to financial institutions or employers for purposes other than payment shall expire after 90 days unless renewed by the patient. Disclosures to the department of corrections (DOC), while the patient is under supervision of DOC, expires at end of the supervision term or end of required treatment. Please see RCW 70.02.050 for information about possible disclosure without patient authorization.