



WASHINGTON
MULTICULTURAL
SERVICES LINK

AUTHORIZATION FOR USE OR DISCLOSURE OF CONFIDENTIAL INFORMATION

By signing this form, you are giving permission for Washington Multicultural Services Link (WMSL) and the agencies listed below to use and share your confidential information. WMSL will not refuse to serve you if you do not sign this form. If you do not sign this form, WMSL may still share your information to the extent allowed by law. If you have questions about how we share your confidential information, please ask the person giving you this form.

Print Name of Client: _____

Date of Birth: _____

Print Name of Parent/Guardian (if applicable): _____

Date of Birth: _____

I. My Authorization

I authorize the following using or disclosing party:

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to use or disclose the following health information.

- All of my health information

- My health information relating to the following treatment or condition:

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

This authorization ends:

- On (date) _____



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- When the following event occurs: _____

II. Client Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Client (or legal guardian): _____

Date: _____