UNIVERSITY PLACE
TMS CLINIC
& GENERAL PSYCHIATRY

P: 253-234-4199
F: 984-302-3631
www.uptms.com
contact@uptms.com
4007 Bridgeport Way W, Ste B
University Place WA-98466

Patient Consent for Use and Disclosure of Protected Health Information/ Release of Information.

I hereby give my consent for University Place TMS & General Psychiatry (as the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the practice may call me, email me or call me at my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked “Personal and Confidential."

Client

Name……

Other Alias name:……

Date of Birth:……SSN……

I hereby authorize the below ***Health Care Providers*** to use or disclose, in verbal and/or written form, the specific information requested below, to University Place TMS Clinic & General Psychiatry for the purpose of receiving TMS & Mental health treatment services.

1. **PCP……Tell……Fax……**
2. **Pharmacy……Tell……Fax……**
3. **Therapist: ……Tell……Fax……**
4. **Hospital: ……Tell……Fax……**
5. **Others: ……Tell……Fax……**
6. **Others:……Tell……Fax……**
7. **Others:……Tell……Fax……**

Record Release.

One-Way Release: …… - OR -Two-Way Release: ……

We have checked the minimum records needed. Please check any other applicable mental health records you authorize us to request.

☒ Treatment Summary	☒ School Testing/Evaluations
☐ Psychological Testing	☐ Medical Information History
☐ Psychological Evaluation	☐ Current / Previous Medications
☒ Psychiatric History	☒ Hospital Admit Summary
☐ Substance Use/Abuse History	☐ Hospital Discharge Summary
☐ School Functioning/Educational	☐ Other:

This authorization shall remain in effect from the date signed below UNLESS otherwise revoked in writing.

I understand that:

1) I may inspect or copy the protected health information to be used or disclosed.
2) I understand that I may revoke this authorization any time (except to the extent that actions have been taken in reliance on it) by submitting a written revocation letter to University Place TMS Clinic & General Psychiatry.
3) Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
4) I may refuse to sign this authorization
5) I hereby release University Place TMS Clinic & General Psychiatry from any and all legal responsibility or liability or for any consequences of either:
   5.1 Having non- stipulated information maintained in confidence or privacy; or
   5.2 Disclosing stipulated information.

Notice to receiving agency:
The patient's record is privileged information, which is protected by various State and Federal laws. Such information may not be disclosed to other persons or entities, including those within the organization wherein the patient is employed, without a separate written authorization from the patient.

Acknowledgement.

By signing this contract, I hereby give my consent for University Place TMS & General Psychiatry (as the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Client Name……

Signature: ……Date……

Print Name: (Legal guardian) ……

Relationship: ……

Signature: ……Date……