Bainbridge Mental Health, PLLC **Britt Gonsoulin, MD, MPH**
PSYCHIATRY PSYCHOTHERAPY CONSULTATION
271 Wyatt Way NE, Suite 200 Bainbridge Island, WA 98110
P: 206-201-3840 f: 206-347-8740

AUTHORIZATION TO OBTAIN OR RELEASE HEALTHCARE INFORMATION

I authorize Bainbridge Mental Health PLLC/Britt Gonsoulin MD, MPH to

☐obtain ☐release information from the records of:

Patient's Name: ________________________________ Date of Birth:_____________

Previous Name:_________________________________

Information to be exchanged with the following entity:

Name: ____

Address: ____

City:__________________ State: ________ Zip Code:_____________

Fax: ________________________Phone: ___________________

I authorize my records to be faxed to the number above. Patient Initial: ________

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

____

Or ______ (check) All healthcare information

For the Purpose of: ____

☐Participation in psychiatric treatment or evaluation services

☐Coordination of Care

☐Transfer of Care to new provider

☐Other:____

_

Please note the following and check appropriate box as desired:

____Yes ____No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

____ Yes ____ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient Signature: ____________________________________Date Signed:______________

TO REVOKE THIS AUTHORIZATION, PLEASE SUBMIT A WRITTEN REQUEST TO US.