



### Authorization for Use and Disclosure of Protected Health Information

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Authorizes (Therapist) \_\_\_\_\_

#### To Obtain/Exchange/Disclose Information To:

Name: \_\_\_\_\_

Please Check Preferred Method(s):

Email: \_\_\_\_\_

*Please be advised that while all emails sent from our office are encrypted, we cannot guarantee confidentiality once it leaves our system.*

Telephone #: \_\_\_\_\_  Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

- Psychiatric information (if written records are disclosed, includes, current prescribed medication, the most recent psychiatric evaluation, and psychiatric medical notes for the past 6 months).
- Other mental health information (if written records are disclosed, includes, the current treatment plan and individual or group progress notes for the past 6 months).
- Other (specify): \_\_\_\_\_

For the purpose of: \_\_\_\_\_

\_\_\_\_\_  
(Initial) DRUG & ALCOHOL: I understand that my records may contain information, diagnosis, or treatment for drug or alcohol abuse. I give my specific authorization for records to be released. (CFR 42, Part 2)

\_\_\_\_\_  
(Initial) STD/AIDS/HIV: I understand that my records may contain information regarding testing, diagnosis, or treatment of STD/AIDS/HIV. I give my specific authorization for these records to be released. (RCW 70.24.105)

**Redisclosure Prohibited: This information has been disclosed to you from records whose confidentiality is protected by state/federal law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person whom it pertains to, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.**

THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME, UNLESS THE AGENCY HAS ALREADY DISCLOSED THE INFORMATION. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE UPON THE REQUEST OF THE CLIENT/PARENT/GUARDIAN.

\_\_\_\_\_  
Signature of Client/Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date