Counseling
Authorization for Use and Disclosure of Protected Health Information

Client Name____DOB _____/_____/__2009_________
month/day/year

hereby authorizes: ____Jeffrey Larson, Ph.D.____ to:

☐ Disclose information to: ☐ Obtain information from: **x** Exchange information with:

Name ____
Organization ____
Address ____
Telephone ____

Information to be disclosed:

☐ 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)

x 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 (specify) __consultation for diagnostic clarification and treatment planning__________________

Specific Authorizations

___ DRUG & ALCOHOL : I understand that my records may contain information, diagnosis or treatment for drug or alcohol abuse. I (Initial)give my specific authorization for records to be released (CFR 42, Part 2).
___ STD/AIDS/HIV: I understand that my records contain information regarding testing, diagnosis, or treatment of (Initial) STD/HIV/AIDS. I give my specific authorization for these records to be released.(RCW70.24.105).

REDISCLOSURE PROHIBITED: This information has been disclosed to you from records whose confidentiality is protected by state or federal law. These laws prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, 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/THERAPIST HAS ALREADY DISCLOSED THE INFORMATION. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE IN NINETY (90) DAYS FROM THE SIGNATURE DATE.

x________________________________ ________________________________
Signature of Client / Legal Representative Date

________________________________ ________________________________
Signature of Witness Relationship of Witness to Client

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