## ANNABELLE DAMPIER, MD

ABPN Double Board-Certified Child, Adolescent and Adult Psychiatrist
Phone/Fax: (425) 256- 3650
Email: Info@DampierMD.com

Authorization to Use and Disclose Protected Health Information (PHI)

Client name:	Previous name:	DOB
Address:		
Phone number:	Email:	
I,(name of client or c	, hereby authorize the lient representative)	ne release of health care informatior
BETWEEN: ANNABELLE	DAMPIER, MD, Psychiatrist, Phone/Fax: (425) 2	256- 3650, Email: Info@DampierMD.co
AND: Name and Org	anization:	
Address:		
Phone/ Fax:		
By signing this Author the following:	rization, I authorize the use and disclosure	of all health information, including
☐ All Health Inform applicable: Yes No	ation about me, including my clinical recor	ds. This information may include, if
	nation about mental health diagnosis or treatm	
□ □ Inforr order	nation on diagnosis or treatment for alcohol or nation on HIV/AIDS Testing or Treatment (inclued, performed or reported, regardless of whet we or negative).	uding the fact that an HIV test was
·	nation about diagnosis or treatment of Sexually	y Transmitted Disease(s).
□ Specific Health In	formation including only:	
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Dother  This authorization ends: (check one box) in one (1) year when the following occurs:  I UNDERSTAND AND ACKNOWLEDLGE THAT: My records may contain information related to my mental health; my written consent is required to release any health care information related to testing, diagnosis, and/ or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and or drug and/or alcohol use unless otherwise allowed or required by law; this authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent; I may refuse to sign this authorization or revoke authorization in writing at any time, except to the						
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Relationship if signed on behalf of the client by parent, legal quardian, personal representative, etc.	Signature of client or le	gally authorized represe	entative [	Date	Time	
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