Hamah Healing, PLLC | Heather Barnes M.A., M.Div., LMHCA

Authorization To Release Information

Name_____ Date of Birth _____

I authorize the specified information regarding the above person may be disclosed between:

_____ **and** _____

Counselor | Third Party

Hamah Healing, PLLC
c/o Heather Barnes M.A., M.Div., LMHCA
1622 3rd Street
Marysville, WA 98270

Phone: **406.426.2484**
hamah.healing@gmail.com

_____
Facility/Organization/Relationship to Client

_____
Street Address

_____
City State Zip

_____
Phone

Please Circle all Specific Information to be Disclosed

Intake Evaluation	Psychiatric Evaluations	Laboratory Results
Number of Sessions Attended	Discharge Summary	Evaluations
Progress Notes	Treatment Plan	Medications
Medical History	Medical Diagnosis	Synthesis of Treatment

Other:_____

I understand that my records may contain information relating to mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel this authorization at any time, except to the extent that the action has already been taken. Unless canceled earlier by me, this authorization will expire in ninety (90) days from the signature date.

Signature: _____ Date: _____

Please indicate whether you are a: Client _____ Parent _____ or a Legal Guardian _____