

CARING SOLUTIONS COUNSELING CENTER

1800 112TH Avenue NE, Suite 320E,
Bellevue, Washington 98004
425.455.0300

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are required by federal law to keep a copy of this completed form in your file whether or not you are requesting that we share protected health information at this time.

I, _____ authorize Caring Solutions Counseling Center, Inc. to disclose to and/or obtain
(Your name)

from: _____ the following information:
(Names of others who you authorize your protected information disclosed to and/or obtained from.)

Which protected information are you authorizing to disclose?

- any and all general assessment or other information regarding my social, emotional, educational, religious, psychological, and/or medical histories, including assessments, background, opinions, and any other relevant data necessary to assist Caring Solutions Counseling Center in providing continuing service to me.
- General Assessment Information Specific to _____

PURPOSE OF DISCLOSURE / EXCHANGE OF INFORMATION:

The exchange of information may be done by telephone, fax, electronic data transfer, or mail, at my request or to coordinate treatment, i.e. in order to process insurance billing.

RELEASE REQUIRING SPECIFIC CONSENT:

I am aware that my records may contain healthcare information relating to testing, diagnosis or treatment for HIV/AIDS, for any other STD, for chemical dependency, and/or for mental health. I specifically authorize Caring Solutions Counseling Center, Inc. to disclose any and all such information, if not excluded by initialing below: If I put my initials below then I intend to EXCLUDE from this Authorization healthcare information relating to testing, diagnosis, or treatment for the following: Chemical Dependency ____, Mental Health ____, HIV/AIDS ____, Sexually Transmitted Diseases ____.

REVOCACTION / RE-DISCLOSURE:

I understand that I may revoke this authorization at any time by giving my health care clinician a written and signed statement of revocation, and that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on the authorization, including provision of health care services requiring subsequent disclosure to effect payment. I also understand that unauthorized re-disclosure of my health information by the recipient is a potential risk. If re-disclosed, privacy laws may no longer protect the information.

DURATION:

If not previously revoked, this authorization will expire two (2) years from today's date OR on _____.

CONDITIONS:

I understand that I have the right to refuse to sign this authorization; however, I also understand that refusing to do so may condition treatment from Caring Solutions Counseling Center, Inc.

Signature of Client Date

Signature of Parent, Guardian or Personal Representative Date