Counseling by Kate, LLC

Kate Knapp Lengyel, J.D., M.S., LMHC, LPC, Mediator

Licensed Mental health Counselor

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

I do hereby consent and authorize _KATE KNAPP LENGYEL, JD, MS, LPC _ to disclose to and receive information from:

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Otherwise confidential information pertaining to my treatment
☐ By transmitting a copy of my **confidential health record in full.**
☐ By transmitting a treatment **summary**
☐ By discussing and exchanging my otherwise confidential information by ☐ phone ☐ email ☐ personal contact
Restrictions or limitations on information to be released (specify):

_____

_____

I understand this information is to be used for the purpose of: (check as many as apply) ☐ Diagnosis ☐ Continuity of Care ☐ Treatment Planning ☐ Discharge Planning ☐ Further Evaluation ☐ Legal Purposes ☐ Insurance Claim(s) ☐ Other _____

- This Authorization may be withdrawn at any time in writing except to the extent that the person(s) which are to make this disclosure have acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. This release of information expires **one year**, except for information to be released or exchanged for purposes of a claim for benefits. If for a claim for benefits, this release of information expires upon termination of coverage under the insurance policy or benefit plan or the final determination of the claim, if later.
- I understand that I am financially responsible for costs involved in this request as outlined in my signed Inform and Consent with Counseling by Kate. I understand that if a subpoena is issued for court appearance I am required to provide Counseling by Kate a financial retainer before the date of the court appearance.
- To the party receiving this information: If the records disclosed to you pursuant to this authorization contain information related to alcohol and/or drug abuse, HIV/AIDS related information, confidential communicable disease information, and/or psychiatric mental health information, the information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2) or by Washington law. The Federal and state rules prohibit you from making any further disclosure of such information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- I understand that the information to be released may contain confidential HIV/AIDS related information, confidential communicable disease information, information relating to drug/alcohol use/abuse/treatment and/or psychiatric mental health information. I authorize the release of the above indicated confidential information. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization who receives the information.
- I understand the matters discussed on this form. I release the provider, officers and directors, staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
- **A copy of this executed release serves the same purpose as an original.**

EXECUTED ON THIS DATE: _____

Patient or Guardian Signature: _____

☐ Check here if you are the legal guardian for the party whose information is to be released.