alderwood
counseling
associates

Authorization to Release Information

Name: ______________________________ DOB: ______________________

Alderwood Counseling Associates, PLLC
19031 33rd Ave. West Suite 303
Lynnwood, WA 98036

425-640-7919
425-640-9087 (fax)

We may: ☐ **Disclose** ☐ **Receive** ☐ **Exchange**
the protected health information indicated below with
Person/Facility: ______________________________
Address: ______________________________
____
Phone: ____________________ Fax: ____________________

I authorize the release of any and all of the following medical or mental health information, as specified, which may be contained in my records (check all that apply).

- ☐ AIDS/HIV*
- ☐ Discharge Summary
- ☐ Drug/Alcohol*
- ☐ Intake Evaluation
- ☐ Laboratory Results
- ☐ Medications
- ☐ Medical Diagnosis
- ☐ Medical History
- ☐ Progress Notes
- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ School
- ☐ Treatment Plan
- ☐ Other: ____________________

Purpose of this disclosure (check all that apply):

- ☐ Assisting in diagnosis & treatment
- ☐ Assuring continuity of care
- ☐ Reporting to Probation Officer or court
- ☐ Coordinating service delivery
- ☐ Determine program eligibility
- ☐ Educating family member(s) about mental illness
- ☐ Referring to another agency/person
- ☐ Other: ______________________________

*________ (initial) I understand that my record may contain information regarding testing, diagnosis, or treatment of **HIV/AIDS** or of sexually transmitted diseases. I give my specific authorization for these records to be disclosed.(RCW 70.24.105)

*________ (initial) I understand that my record may contain information regarding diagnosis or treatment of **drug or alcohol** abuse. I give my specific authorization for these records to be disclosed. (42 CFR, Part 2)

I understand that my records may contain information relating to mental health issues (per RCW 71.05.620). This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that information used or disclosed in keeping with this authorization may no longer be protected by Federal Law and could be used or re-disclosed by the receiving party. This consent is subject to my revocation at any time, except for information previously exchanged. To revoke this authorization I must submit a written request to Alderwood Counseling Associates, PLLC. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Alderwood Counseling Associates, PLLC.

Unless revoked earlier by me, this authorization shall expire either 30 days after the signature date, or upon discharge from mental health services at Alderwood Counseling Associates, PLLC, whichever is **later**.

____ ____________________
signature of client, client's parent/legal guardian **date**