Transformative
Counseling & Family Services

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Release of Information

Date: _______________

Patient name: _________________________________ DOB: _______________

This is to authorize that the information specified below regarding the above named person be disclosed between _________________________________ of Transformative Counseling and Family Services and:

Name: _________________________________

Organization: ____________________________

Address: ________________________________

____

Phone: _________________________________

Fax: ___________________________________

Information to be disclosed:

- ☐ Medical ____
  I understand my records may contain information regarding testing, diagnosis or treatment of STD, HIV or AIDS. I give my specific authorization for records to be released. (RCW 70.24-105)
- ☐ Mental Health ____
- ☐ Chemical Dependency ______________________________________
  I understand my records may contain information diagnosis or treatment for drug or alcohol abuse. I give my specific authorization for records to be released. (CFR 42, Part 2)
- ☐ School ____
- ☐ Legal ____
- ☐ Other ____

For the purpose of ____

I understand that my records are protected under Federal and State Law and cannot be disclosed without my written consent unless otherwise provided for by law. My consent automatically **expires/ terminates upon completion of treatment**. I understand that I can revoke my consent at any time ept to the extent that action has been taken in reliance on it.
I acknowledge that the information to be exchanged and released was fully explained to me, and I hereby consent to it.

Patient Signature____________________________ Parent/Guardian Signature ____________________
Date: ______________________ Date:____________________