Connections Counseling Services NW
33301 1st Way S. C-140
Federal Way, WA 98023
(253) 625-5942
https://connectionscounselingnw.com

Connections Counseling Services NW
5900 - 100th St SW, Suite 16 &17B
Lakewood, WA 98499
(253) 625-5942
https://connectionscounselingnw.com

Authorization to Disclose Protected Health Information

Patient information:

Client name (printed):_____
DOB:_____

Parent and/or Guardian:_____

Clinician name: _____

Send information to:

- Self
- Provider/Organization

Name of Provider/Organization:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone number:_____ Fax:_____

Purpose of Request:

- Transfer of care
- Self
- Other:_____.

Information to being requested:

- Therapeutic records (Treatment Plan/Notes)
- Chart notes
- Dates of service

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Minor age 13-17 years: A minor client's signature is required in order to release information pertaining to mental health conditions.

I hereby consent to the release of the specified information relating to diagnosis or treatment to the person or organization named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of client health information to the above-named person or organization. You have the right to revoke or cancel this authorization, in writing at any time.

There is .50 cent charge per page for copies of requested information.

Client Signature:_____
Date:_____

Parent/Guardian signature:_____
Relationship to client:_____
Date:_____

For Office Use Only
Completed by:_____ Date:_____
Note:_____