John Jordy, M.Ed., LMHC
Washington State Licensed Mental Health Counselor #5876
Bellwether Way, Ste. 223 Bellingham, WA 98225 Phone: 360.255-0772 Fax: 360-255-0773

Authorization for Disclosure of Health Information

Client Name: _____ Birth Date: ____/____/____ SS#:_***-**-____

Previous Name(s): _____Address: _____

I authorize John Jordy, M.Ed., LMHC to release/exchange the following information. I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment.

INITIAL ANY INFORMATION TO BE RELEASED

_____Psychological / Psychiatric records
_____Chemical dependency/substance abuse Treatment
_____Psychological testing
_____Other:_____
_____Evaluation and Treatment
_____HIV/AIDS and/or sexually transmitted diseases
_____Dates only of sessions/contact

TO/WITH:

Name: _____
Address: _____
_____
_____
Phone: _____Fax: _____

TO/WITH:

Name: _____
Address: _____
_____
_____
Phone: _____Fax: _____

I understand that I may revoke this Authorization in writing at any time.

_____ _____

Signature of Client Date

For children 12 and under, parent/guardian signature is required.

For children age 13 and over, the parent/guardian is encouraged to sign, but it is not required.

I understand that the client is a minor and that the information being requested for the above may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment.

I consent to the disclosure of such information.

_____ _____

Signature of Parent/Guardian Date