

Susan Ward, MA, LMFT

1900 Dock Place, Ste. 7, Seattle, WA 98107 / 206-786-0094

Request/Authorization to Release Confidential Records and Information

This authorization allows mutual exchange of information between the individual or organization listed below and Susan Ward, MA, LMFT until 90 days after discharge from this term of treatment.

Person or facility: _____

Address: _____

Phone: _____ Fax: _____

This authorization pertains to records and information concerning and/or regarding _____, born on _____, and whose Social Security number is _____, for the following purpose(s):

____ Further mental health evaluation, treatment, or care

____ Rehabilitation program development or services

____ Treatment planning

____ Research

____ Other, specify: _____

The information to be disclosed is as follows:

____ Intake and discharge summaries

____ Medical history and evaluation(s)

____ Mental health evaluations

____ Developmental and/or social history

____ Educational records

____ Progress notes, and treatment or closing summary

____ Other : _____

The purpose of the disclosure:

____ Legal ____ Referral ____ Care coordination

____ Discharge Planning ____ Other: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ____ Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer protected by federal privacy regulations.

Signature of client

Printed name

Date

Signature of parent/
guardian/representative

Printed name/Relationship

Date

Signature of witness

Printed name

Date