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Authorization to Use and Disclose Confidential Health Information

Client name Date of Birth

I authorize Dr. Valerie Correa to:
______ (initial) Release the following information to:
______ (initial) Receive the following information from:

Person and/or Agency

Address

City, State, Zip

Phone Number Fax Number

This information is needed for the following purposes (initial each applicable line) :
______ Mental Health Treatment Planning, Consultation and Continuity of Care
______ Diagnosis and Evaluation
______ Other: ____

The information to be disclosed includes (initial each applicable line) **:**
______ Information about past/current treatment
______ Assessments/Testing/Psychiatric Reports
______ Consultation
______ Physical health/medical information
______ Treatment Summary
______ Medications in Treatment
______ Treatment goals, Progress and Results
______ Financial/Billing Information
______ Psychiatric and Mental Health information included in these records
______ Alcohol and Drug Treatment Information (this is specifically protected by the law)
(*I understand that Dr. Valerie Correa cannot guarantee that the recipient of this information will not re-disclose my health information to another party. The recipient is prohibited by law from making further disclosure of this information unless further consent for me has been obtained, unless otherwise permitted under 42 CFR, Part 2).*
_____ AIDS/HIV/other STD testing information (this is specifically protected by law)
_____ Other: ____
_____ This authorization has been initiated by the client and the client does not elect to disclose its purpose (Note: This box may be checked if the information requested pertains to alcohol or drug abuse, diagnosis, prognosis or treatment).

I understand that my records are protected under the federal and state confidentiality regulations (including HIPPA, CFR 42 part 2, RCW 71.05, 70.02, 71.34, 74.04, 13.50, 100(4)(b) and WAC 388-865-0436 or its successor), and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my psychologist, Dr. Valerie Correa cannot guarantee that the recipient of this information will not re-disclose my health information to another party. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

This authorization shall remain in effect until ________ (no longer than 90 days from date of signature), or until 30 days after the end of treatment.

I understand my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

Client Name Date

Parent/Guardian/Legal representative's Signature (required if clien5t is under 18 or is not competent to give consent) Date

Witness Signature Date