AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

HUMAN DEVELOPMENT AND STRESS MANAGEMENT CENTER, LLC
1007 Scott St. Suite F
Bremerton, WA 98310
(Office) 360-377-9032 (Fax) 360-377-0129

CLIENT NAME:_____ DOB:_____

I understand that the authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand that I may request details of disclosures made from my records and that not all disclosures require tracking, thus may not be part of the record. If requested, this disclosure will be provided in 15 days. I understand that a disclosure of my information carries with it the potential for an unauthorized re-disclosure to a third party and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my therapist at the above number.

Disclose to_____ Receive from_____

Person/Agency:_____
Adress:_____ City:_____
State:_____ Zip:_____ Phone:_____ Fax:_____

I understand this disclosure may include mental health/psychiatric information & may be disclosed by phone/mail/fax. Checkmark the type of information to be disclose (include dates when appropriate)

Treatment Plan _____

Assessments, evaluations & treatment summaries _____

Clinician's notes _____

Academic information, school testing _____

Medical Information _____

Alcohol/drug treatment information _____

AIDS/HIV or other STD information _____

Purpose of Disclosure: Treatment planning & continuity of care_____
For all other reasons, specify:_____

This release is effective for one year. I understand that I the right to revoke this authorization at any time. The revocation must be made in writing. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to circumstance where state or federal regulations require access to information for specific incidents including, but not limited to, reports of abuse, neglect, or domestic violence, for qualified research/audit, reporting to a public health authority to prevent/control disease, emergency medical care, or court order.

CLIENT'S SIGNATURE:_____ DATE:_____

PARENT'S SIGNATURE;_____ DATE:_____