AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS

Cascade Counseling

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2100 Caton Way SW * Olympia, WA, 98502

I,_____ DOB:_____

hereby give my permission to **CASCADE COUNSELING**, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be released upon request to the following:

To: _____

First and last name, phone and/or fax number

The type of information to be disclosed/requested is as follows:

To Be Released * *from* ***Cascade Counseling***

____Treatment Plans

____Process Notes

____Health/Medical Records (if applicable)

____Letter(s) of Progress

____Bio Psychosocial Evaluation/Assessment (if applicable)

____Scheduling and Billing

____Other (Specify): _____

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **CASCADE COUNSELING.**

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **CASCADE COUNSELING** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **CASCADE COUNSELING**. **CASCADE COUNSELING** will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **CASCADE COUNSELING** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire one year after signing. This agreement is subject to revocation in writing at any time.

Release:

_____

Signature Client/Next of Kin/Guardian Date

_____

Clinician Signature/Credentials Date