

Conscious Choices Counseling Services

Nancy Paul, M.A., L.MFT, L.MHC
402 S. 333rd St. #127
Federal Way, WA. 98003

WWW.TherapyWorks.ws

Ph: (253) 874-6528
Fax:(253) 929-1597

AUTHORIZATION TO RELEASE/TRANSFER MEDICAL RECORDS

PATIENT: _____ DOB: _____ I.D.# _____

1. **AUTHORIZATION FOR RELEASE.** I hereby authorize **CONSCIOUS CHOICES COUNSELING**
NANCY PAUL, M.A., L.MFT, L.MHC
402 S 333rd St. #127
FEDERAL WAY, WA 98003

to release, disclose, and deliver the medical information described below to:

(Name) _____ of (Company) _____

(Address) _____

(Phone/Fax/Email) _____

2. **SPECIFIC AUTHORIZATION.** By initialing all information items I approve, I authorize release of the following medical information.

___ Mental Health Diagnosis

___ Medication Management Information

___ HIV/AIDS related records (Except HIV test results)

___ Other Mental Health treatment information

___ Substance Abuse information

Substance Abuse information is limited to the following treatment _____.

For the following time period _____.

___ Other information _____.

This authorization includes reports, correspondence, test results, and any other information in the records, whether generated by the authorized provider or another entity. I do not give permission for any other use or redisclosure of the information.

Signed: _____ Date: _____ Signed: _____ Date: _____

Printed Name: _____ Printed Name: _____

Signed: _____ Date: _____ Signed: _____ Date: _____

Printed Name: _____ Printed Name: _____

3. REDISCLOSURE. This release does not authorize redisclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for any purpose other than that already stated and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I specifically understand and agree that the redisclosure requirements set out above will apply to these records.

4. VALIDITY. I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care that I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient(s) only. Additional information may be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

I AUTHORIZE THE RELEASE OF INFORMATION AS INDICATED ABOVE.

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Signature of Legal Guardian if patient is a minor: _____ Date: _____

