La Perla Counseling and Trauma Response Services, Inc.

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Authorization for Use and Disclosure of Protected Health Information

For Purposes Requested by ☐ Provider or ☐ Patient

Name of Client:_____ **Date:**_____

Name of Provider/Recipient of Information: _____

Address: _____

_____

Phone:_____ Fax:_____ Email:_____

Age:_____ D.O.B.:_____ Attorney:_____

Check one: ___ Insurance ___ Other:_____ Deliver copies by: ☐ Mail ☐ Email ☐ Fax

For the following purposes:_____

_____

Types of Information to be Disclosed:

☐ Entire Medical Record ☐ Office Chart Notes ☐ Discharge Summary ☐ All Hospital Records
☐ Emergency and Urgent Care Records ☐ Medical Records for Continuity of Care ☐ Police Reports
☐ Substance Abuse Treatment Reports ☐ Teacher Reports ☐ Guardian Ad Lietem Reports

Extent of Information:

I am aware that these records may contain information concerning the testing, diagnosis, and treatment for HIV/AIDS, other sexually transmitted diseases, and/or substance abuse services governed by 43 CFR Part 2, and/or mental health services governed by RCW 71.

Revocation:

It is my understanding that this authorization can be revoked at any time, except to the extent that use and/or disclosure made in good faith may have already occurred in reliance on this authorization.
Revocation Date:_____ *Re-disclosure Date*: _____

Expiration:

If not previously revoked, this authorization will expire 180 days from the date of signing or (date):_____
(*Specific limitation*: Except as to third-party payers, this authorization does not include disclosure for health care services received more than ninety (90) days from the date of last signature.)

Signature:

My signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of that signature (initial or renewal). I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment, or eligibility for benefits.

Initial Signature:_____ **Date:**_____

Printed Name of Patient's Representative (If applicable):_____

Witness:_____

Renewal Signature:_____ **Date:**_____

Printed Name of Patient's Representative (If applicable):_____

☐ **Sonja Rudie, MA, LMHC, CSAT, C-EMDR** ☐ **Julia Jenkins, MA, LMHC-A, CSAT-C, A-SOTP**
☐ **Blair Schmautz, MA, LMHC, CSAT** ☐ **Steve Sandvik, MA, LMHC** ☐ **Kerry Fitzgibbons, MA, LMFT, CEAP**