

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 Litem 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 Blair Schmautz, MA, LMHC, CSAT Steve Sandvik, MA, LMHC
 Kerry Fitzgibbons, MA, LMFT, CEAP Danielle Melton, MA, LMHC, NCC
 Kristine Zimmerman, MA, LMHC, CSAT, CMAT