Authorization to Use and Disclose Protected Health Information (PHI)

Client Name	Client Date of Birth

Client Address_____

Client Phone Number_____ Client Email_____

I, _____, **hereby authorize the release of health care information BETWEEN:**
(name of client or client representative)

Fred Matheson, MA, LMHC of A Vagabond's Journey Counseling
(a Licensed Mental Health Counselor in the State of Washington)
1914 N 34th St, Ste 504, Seattle, WA 98103
206-569-4937

AND:

Name and Organization: _____

Address: _____

Phone: _____ FAX: _____

By signing this Authorization, I authorize the use and disclosure of the following health information:

☐ All Health Information about me, including my clinical records.

☐ Specific Health Information *including only:*

____Intake Evaluation	____Discharge Summary	_____Crisis Plan
____Psychological Evaluations	_____Progress Notes	_____Treatment Plan
____Medical History	_____Diagnosis Summary	_____Medications
____Medical Diagnosis	_____Billing/Financial Info	

____Other: (specify)_____

For the purpose(s) of: ☐ Continuity of care ☐ Client request ☐ Disclosure for legal purposes

☐ Other:_____

This authorization ends: (check one box)

☐ in one (1) year ☐ ninety (90) days from termination of the counseling relationship

I UNDERSTAND AND ACKNOWLEDGE THAT: My records may contain information related to my mental health; my written consent is required to release any health care information related to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use unless otherwise allowed or required by law; this authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent; I may refuse to sign this authorization or revoke authorization in writing at any time, except to the extent that the action has already been taken in reliance of it; information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by this provider, office, or HIPAA regulation; and commencement, continuation, or quality of treatment will not be conditioned on whether I sign this document except insofar as PHI is necessary to assessment report, or treatment contemplated by this authorization. However, failure to sign here may result in a denial of insurance benefits by your insurer. PHI may be conveyed in writing, fax, or verbal/telephone communication. I have received a copy of my signed authorization.

I hereby release the provider and recipient of my PHI from any and all legal liability that may arise from the use and disclosure of information as set forth in this Authorization.

_____ _____

Signature of client or legally authorized representative Date Time

_____

Relationship if signed on behalf of the client by parent, legal guardian, personal representative, etc.