Authorization to Release
Protected Health Information

1. I am completing this form to allow the use and sharing of protected health information about:

Printed name: _____ **Date of Birth:** _____

2. I authorize the following person or organization:
Lillie McCatty, LMHC
PO Box 12962 • Olympia, WA 98508-2962 • 360-259-7179

3. To receive or disclose the following information:

□ Inpatient or outpatient treatment records for physical and/or mental health.

□ Admission and discharge summaries

□ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or similar

□ Treatment, recovery, rehabilitation, aftercare plans and other similar plans.

□ Social, family, educational, and vocational histories, evaluations, assessments, and reports.

□ Academic and educational records, including IEPs, 504s, achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.

□ Complete copy of the medical and or mental health record.

□ Other: _____

4. To or from this person or organization:

_____

5. The information will be used/disclosed for the following purposes:

_____

6. I understand that I can revoke or cancel this authorization at any time by sending a letter to Lillie McCatty. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 4 above, nor will it affect my eligibility for benefits.

8. I understand that I may inspect and have a copy of the health information described in this authorization.

_____ _____
Signature of client (or parent/guardian if under 12) Date

_____
Printed name of client or (or parent/guardian if under 12)

_____ _____
Lillie McCatty, LMHC Date