AUTHORIZATION FOR DISCLOSURE of PROTECTED INFORMATION

CLIENT NAME: _____ DATE OF BIRTH: _____

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
ATTENTION: _____	ATTENTION: _____
ORGANIZATION: _____	ORGANIZATION: _____
(city, state, zip)	(city, state, zip)
PHONE:	PHONE:

_____ ☐ THIS AUTHORIZES MUTUAL EXCHANGE OF INFORMATION BETWEEN THE ABOVE ENTITIES
CLIENT INITIALS ☐ N/A

PURPOSE OF DISCLOSURE

SPECIFIC INFORMATION TO BE DISCLOSED

LIST SPECIFIC INFORMATION/DOCUMENTS TO BE DISCLOSED:

SPECIFIC AUTHORIZATIONS

AIDS/HIV/STDs
☐ YES ☐ NO ☐ N/A — I understand that my records may contain information regarding testing, diagnosis, and/or treatment of HIV/AIDS, or sexually transmitted diseases. I give my specific authorization for these records to be released. (Per RCW 70.24.105)

Drug/Alcohol
☐ YES ☐ NO ☐ N/A — My records may contain information regarding diagnosis and/or treatment for drug or alcohol abuse. I give my specific authorization for these records to be released.

_____ ☐ N/A
CLIENT INITIALS:

SIGNATURES

☐ (1) I understand that my records may contain information regarding mental health diagnosis and treatment, drug and/or alcohol abuse, the testing, diagnosis or treatment of HIV/AIDS and/or sexually transmitted diseases. I give my specific authorization for these protected records to be released. *(If you do not want these records released, you must complete the box below).*My records are protected under the Federal and State statutes and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

☐ (2) **I DO NOT want the following information to be released** (If nothing is specified, all information will be included):

(3) Disclosed information may potentially be re-disclosed by the receiving party; information relating to mental health, drug/alcohol, HIV/STD's are specifically prohibited by law to be re-disclosed. I understand that I may revoke this authority at any time, except to the extent that action has already been taken. To revoke this authorization, it must be in writing and submitted to Cauthers Counseling. Cauthers Counseling is prohibited from conditioning treatment, payment, enrollment or eligibility for benefits on my agreement to sign this authorization. Unless cancelled earlier by me, this authorization will expire 1 year from the signature date. A copy or FAX shall be considered valid in lieu of the original.

Any Minor child thirteen (13) years or older has all the rights provided by Chapter 388-865 WAC to clients receiving outpatient services. Therefore, these minor clients must sign authorizations for release of client information.

SIGNATURE OF CLIENT _____ DATE _____ SIGNATURE OF GUARDIAN _____ Date _____

SIGNATURE OF WITNESS _____ DATE _____

ALL APPLICABLE SECTIONS ON THIS AUTHORIZATION FORM MUST BE COMPLETED FOR THIS RELEASE TO BE VALID.

90-Day Update Of Authorization

	SIGNATURE	DATE	WITNESS
1.			
2.			
3.			