DLSMITH COUNSELING
Release of Information Form

I**, (Name of Client)** _____(**DOB)**_____/_____/_____, give permission for **(Name of Provider)** _____ to disclose, exchange or receive information from the entity listed below.

Name: _____

Address_____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax** _____

INFORMATION REQUESTED: (Initial appropriate boxes)

☐ **Entire Chart including HIPAA protected Progress Notes**

Initial appropriate boxes if you do not wish to disclose everything

☐ **Progress Notes**	☐ **Psychiatric Evaluation**	☐ **Summary of Progress**
☐ **Psychosocial Assessment**	☐ **Medication Records**	☐ **Consultation Reports**
☐ **Treatment Plan**	☐ **Laboratory Reports**	☐ **Termination Summary**
	☐ **Psychiatric Admit Note**	

☐ Other (Please Specify): _____

By signing this agreement, I am allowing the release of information for Mental Health, Drug and Alcohol Abuse or Treatment, HIV/AIDS information and any information regarding Sexually Transmitted Diseases.

This authorization ends: (If nothing is marked, this will expire one year from the signed date below)

☐on (date): _____☐ when the following event occurs: _____

II. My Rights

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health care information for a third party.
- I may revoke this authorization in writing. If I do, it would not affect any actions already taken by Deborah Smith Counseling and other providers at 6917 W Grandridge Blvd Location based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
- Fill out a revocation form. A form is available from Deborah Smith Counseling or Write a letter to Deborah Smith LMHC.
- Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.
- I understand there may be charges associated with my request for records. Such charges shall not exceed the amount allowable under RCW 70.02.
- Any minor child thirteen (13) years or older has the same rights as an adult to voluntarily seek treatment and must give written consent for records to be released to others, **including parents**. Therefore, minor clients must sign authorization for us to release that client information within the statutes of the law.

_____ _____

Print name (If signed on behalf of patient) Relationship to patient

_____ _____

Signature of client/ Parent or Guardian Date