AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

RELEASE OF INFORMATION

Authorization for Use/Disclosure of Information:

I voluntarily consent to authorize Healthy Counseling Center to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below. I understand that I have a right to receive a copy of this authorization. I understand that I have the right to revoke this authorization at any time.

I authorize:

Name: _____
Address: _____
Phone# _____

to release my health care information to the following recipient(s).

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____
Address: _____
Phone# _____

Information to be disclosed:

- Acknowledgement of participation in HCC
- Initial assessment and progress notes
- Diagnosis
- Allowance for participation HCC with client
- Recommendations regarding treatment for educational services and placement
- Current behavioral functioning, mental/emotional state and/or education problems
- Informational regarding type of service, medication, client's response to treatment, and prognosis
- Opinion on client's ability to perform employment duties
- Other: information regarding appointment date and times
- School reports (including IPE, teacher questionnaires)
- Collateral information to substantiate mental health concerns, case status, recommendations for services, alerts to special problems, and appropriate treatment
- Legal (including predispositional reports, court orders, and probation contracts)

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- Only the following records or types of health information: _____.

Term: I understand that this Authorization will remain in effect:
- One year from the date of these authorizations.
- Until the Provider fulfills this request.
- Until the following event occurs: _____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation, or quality of my treatment at HCC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the HCC at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the HCC, 9507 North Division Street, Spokane, WA 99218. Phone (509) 466-6632.

_____ _____

Signature Date

_____ _____

Signature (age 13 to 17) Date