Discover Healing

Counseling Services

Release of Information

Name: (last) (first) (M.I.)	DOB:
Previous/Maiden Name or Alias:	

Discover Healing

Address: 512 91st Ave. Suite C
Lake Stevens, WA 98258
828 2nd Street Suite H
Mukilteo Wa 98275

Phone: **425-870-0895**

Fax: 425-**377-1764**

Attn: _____

Discover Healing Clinicians may ☐ Disclose ☐ Receive

☐ **Exchange the protected health information indicated below with**

Person or Facility: _____

Address: _____

_____

Phone: _____

Fax: _____

I authorize the release of **any and all of the following medical or mental health information, as specified,** which may be contained in my records. (Check all that apply)

☐ AIDS/HIV*	☐ Medications	☐ Psychological Evaluations
☐ Discharge Summary	☐ Medical Diagnosis	☐ School
☐ Drug/Alcohol*	☐ Medical History	☐ Treatment Plan
☐ Intake Evaluation	☐ Progress Notes	☐ Other:
☐ Laboratory Results	☐ Psychiatric Evaluations	☐ All

Purpose of this Disclosure: (check all that apply)

☐ ITA investigation/coordination	☐ Determine program eligibility
☐ Assisting in diagnosis and treatment	☐ Educating family member(s) about mental illness
☐ Assuring continuity of care	
☐ Facilitating resident placement	☐ Referring to another agency/person
☐ Reporting to probation officer or court	☐ Other
☐ Coordinating service delivery	Specify: _____

**Please initials below*

I understand that my record may contain information regarding diagnosis or treatment of drug or alcohol abuse. I give my specific authorization for these records to be disclosed. (42 CFR, Part 2)	Drug/Alcohol
I understand that my record may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or of sexually transmitted diseases. I give my specific authorization for these records to be disclosed. (RCW 70.24.105)	HIV/AIDS

I understand that my records may contain information relating to mental health issues (per RCW 71.05.620). This authorization prohibits further use or disclosure of the information being released beyond the specific limits for this consent. I understand that information used or disclosed in keeping with this authorization may no longer be protected by Federal Law and could be used or re-disclosed by the receiving party. This consent is subject to my revocation at any time, except for information previously exchanged. To revoke this authorization, I must submit a written request to Discover Healing. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment.

Unless revoked earlier by me, this authorization shall expire either 30 days after the signature date, or upon discharge from mental health services with Discover Healing, whichever is *later*.

_____ _____

Signature of client, or client's parent/guardian/legal representative Date