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| Client Name/DOB | Previous/Maiden Name or Alias |

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| Close Reach Counseling  Attention: Taylor Evans, MA, LHMC  Address: 509 Olive Way Ste 858  Seattle, WA 98101  Phone: (206) 790-8564  Fax: (206) 238-9692 | Protected information may be  ❑Disclosed ❑Received ❑Exchanged  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

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| ❑ Mental Health Assessment  ❑ Behavioral Health Diagnosis  ❑ Treatment/Crisis Plans  ❑ Progress Notes  ❑ Progress Reports/Reviews  ❑ Discharge Summary  ❑ School Records  ❑ Psychiatric Evaluations  ❑ Nursing Assessment  ❑ History and Physical | ❑ Medical Diagnosis  ❑ Medical History  ❑ Medications  ❑ Laboratory Results  ❑ HIV/AIDS  ❑ Substance Use Disorder Assessment  ❑ Results of Urinalysis/Breathalyzer and/or Lab Tests  ❑ Substance Use Abstinence Status  ❑ Attendance Records  ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| ❑ Assisting in diagnosis and treatment  ❑ Assuring continuity of care  ❑ Facilitating resident placement  ❑ Coordinating service delivery | ❑ Determine program eligibility  ❑ Educating natural supports about behavioral health issues  ❑ Referring to another agency/person  ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 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 71.05.390) and or substance use disorders (42 CFR Section 2). This authorization prohibits further use or disclosure of the information being released beyond the specific limits for this consent. I understand that Close Reach Counseling cannot be responsible for the disposition of the released information once disclosed to the receiving party. This consent is subject to my revocation at any time, except for information previously exchanged. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain enrollment, treatment (or payment, if applicable) from Close Reach Counseling. Close Reach Counseling reserves the right to utilize any and all secure methods for releasing the information specified above.

Unless revoked earlier by me, this authorization shall expire either 30 days after the signature date, or upon discharge from services at Close Reach Counseling, whichever is later.

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

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Signature of Therapist Date