Authorization for the Use or Disclosure of Protected Health Information

Name of client: _____ Date of birth: _____

I understand that the purpose of this release is to assist with my/this patient's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the patient's life. To further this goal, I authorize this therapist to release the below-specified information regarding me/the patient to the individual(s) listed below, and to receive information from them.

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Our New Experience *(ONE), LLC*
Phone: 425-324-7336 Email: ournewexperiences@gmail.com

The information to be disclosed is marked by an **X** below.

Intake Assessment ____ Treatment Plan ____ Discharge plan ____ Treatment summary ____
Psychological evaluation _____ Medications _____ Other _____

I am aware that my records may contain health care information relating to testing, diagnosis, or treatment for HIV/AIDS or for any other STD, for chemical use/dependence, and/or mental health.

Information can be transmitted by Verbal Disclosure ____ US Post _____ Fax _____ Hand Delivered by Client___

This information is to be disclosed to the following individuals who have the indicated relationship to me/the client:

_____ _____
Name of person Relationship

_____ _____
Name of person Relationship

I understand that I may revoke this authorization in writing at any time; that the provider will make a *Revocation of Authorization* form available to me; that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on this authorization, including provision of health care services requiring subsequent disclosure to effect payment. I understand that Department of Social and Health Services' certified drug and alcohol programs will honor verbal revocations upon authenticating my identity.

I understand that re-disclosure of my health information by Recipient, if unauthorized, is a potential risk. If re-disclosed, privacy laws may no longer protect the information. I understand that I do not have to sign this authorization in order to obtain treatment benefits from the Provider, except for health care services necessary to create any assessment or report contemplated by this authorization. I understand that I am entitled to a copy of any authorization I sign.
The effective date of this authorization will be the date of my signature below. If not previously revoked, this authorization **will expire in 90 days or upon the following date** _____, or upon the following event: _____.

_____ _____ _____
Signature of client Printed name Date

_____ _____ _____ _____
Signature of parent/guardian/representative Printed name Relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of witness (Second witness is needed if person is unable to give oral consent.)	Printed name	Relationship	Date

- Copy for patient or parent/guardian • Copy for provider/therapist/case manager • Copy for family member