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AUTHORIZATION TO RELEASE INFORMATION

(Deliver this completed form by hand or send by fax to: (425) 640-8997.)

Client: _____ **Date** _____

I authorize Susan Ruby, MA, LMHC, to exchange or release the following information to facilitate informed services:

- ☐ Information on Previous Treatment
- ☐ School Records & Performance
- ☐ Medical Information
- ☐ Medication Management
- ☐ Progress in Treatment
- ☐ Evaluation Results
- ☐ Mental Health
- ☐ Appointment Scheduling

With: Person: _____

Organization: _____

Street: _____

City/State/Zip: _____

Phone: _____ Fax: _____

I understand that this consent expires upon my termination of treatment.

I understand that records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems are protected under federal confidentiality regulations (42 CFR, Part 2—Alcohol and Drug) and cannot be disclosed without my written consent. I also consent to the release of that information. _____ (client initials)

I understand that my records may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or sexually transmitted diseases. I consent to the release of that information. _____ (client initials)

Other parties receiving this information are prohibited from re-disclosing these records, unless expressly permitted by my written consent, unless disclosure is otherwise permitted by federal regulations.

I understand that I can terminate this consent at any time in writing.

_____ _____

Client or Client's Parent or Legal Guardian *Date*