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AUTHORIZATION TO RELEASE INFORMATION

Deliver this completed form by either fax to (425) 286-6116 or by email to susanrubylmhc@comcast.net

Client Name: ______________________________ Date of Birth: ______________

I authorize Susan Ruby, MA, LMHC, to exchange or release the following information to facilitate informed services and coordination of care. I understand that this consent automatically expires upon termination of treatment, and that I can terminate this consent at any time in writing prior to ending treatment.

- ☐ Information on Previous Treatment
- ☐ Evaluation Results
- ☐ Medication Management
- ☐ Appointment Scheduling
- ☐ Progress in Treatment
- ☐ Medical Diagnoses
- ☐ Mental Health
- ☐ Safety Concerns

with

Person: ______________________________

Organization: ______________________________

Street Address: ______________________________

City, State & Zip Code: ______________________________

Phone: ______________________________

Fax: ______________________________

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.

Client's Signature: ______________________________ Today's Date: ______________