Authorization for Use and Disclosure of Protected Health Information

Client Name:

Date of Birth:

Social Security Number:

hereby authorize Ithemba Counseling to:

[ ] Disclose information to [ ] Obtain information from [ ] Exchange information with

I authorize the person or organization below to disclose information to Ithemba Counseling:

Name:

Organization:

Address:

Telephone

Information to be disclosed:

[] School Information [] I.E. P. [] Clinical Reports [] Medical Reports

[] Psychiatric Evaluation [] Psychological Reports [] DSHS Reports

[] Other

Specific Authorization

\_\_\_\_\_\_\_\_ Drug & I understand that my records may contain information, diagnosis, or treatment

(Initial) Alcohol: for drug or alcohol abuse. I give my specific authorization for records to be released (CFR 42, Part 2).

\_\_\_\_\_\_\_\_STD/AIDS/HIV: I understand that my records contain information regarding testing,

(Initial) diagnosis, or treatment of STD/AIDS/HIV. I give my specific authorization for these records to be released (RCW 70.24.105).

REDISCLOSURE PROHIBITED: This information has been disclosed to you from records whose confidentiality is protected by state or federal law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information in NOT sufficient for this purpose

THIS AUTHORIZATION IS IN EFFECT FOR/UNTIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials\_\_\_\_\_\_\_\_\_

THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME, UNLESS THE AGENCY HAS ALREADY DISCLOSED THIS INFORMATION. IF NOT PREVIOUSLY REVOKED or IF ANOTHER DATE IS NOT INDICATED, THIS CONSENT WILL TERMINATE IN NINETY (90) DAYS FROM THE SIGNATURE DATE.

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Signature of Client/Legal Representative Date

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Signature of Witness Relationship

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Printed Name of Witness

Revised 03/23/20