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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client/Patient's Name: **Date of Birth**:

Information to be Released *FROM:*	Information to be Released TO:
Pacific Northwest Psychology & Consulting ___________________________________ *Organization or Individual* _______________________________________ *Street Address, City, State, Zip Code* ____ *Phone Number* *Fax or e-mail*	**Pacific Northwest Psychology & Consulting** ___________________________________ *Organization or Individual* _______________________________________ *Street Address, City, State, Zip Code* ____ *Phone Number* *Fax or e-mail*

Information to be Released:

Medical Records
Psychiatric evaluation/records
Evaluation Report
Behavioral information

Verbal communication of treatment information
Current IEP/School psychology evaluation reports
Medications
Other: ___________________________________

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ____ Date signed:

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.