Authorization of Disclosure of Information

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Safe Space Counseling

615 North 2nd St., Tacoma, WA 98403

(253) 292-6756

I understand that I may authorize Safe Space Counseling to disclose my private health care information to a third party and if I request disclosure of my private health care information to a third party, my provider will honor that request unless there is a valid legal exception.

I understand that Safe Space Counseling may charge a reasonable fee for providing my health care information to a third party, and my request may not be honored until the fee is paid.

I hereby authorize my Safe Space Counseling to (check all that apply):

□ disclose;

□ obtain;

□ share

my private health information as specified below.

The nature of the information to be disclosed, obtained, and/or shared is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The information to be disclosed, obtained, and/or shared specifically

□ **does** include

□ **does not** include

information related to substance abuse assessment and treatment

The information specified above will be disclosed to, obtained from, or shared with:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institutional/Agency Affiliation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization of disclosure of my health information will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 (date or event)

I understand that if the disclosure is being made to a financial institution or to my employer for purposes other than payment, Washington State law requires this authorization to expire no later than ninety (90) days after signing.

I understand that I have the right to revoke this authorization at any time.

By signing this document, I am attesting that I have received, read, and fully understand and consent to the disclosures, terms, and conditions above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor Print Name