Susan Ward, MA, LMFT
1900 Dock Place, Ste. 7, Seattle, WA 98107 / 206-786-0094

Request/Authorization to Release Confidential Records and Information

This authorization allows mutual exchange of information between the individual or organization listed below and Susan Ward, MA, LMFT until 90 days after discharge from this term of treatment.

Person or facility: _____

Address: _____

Phone: _____ Fax: _____

_____

This authorization pertains to records and information concerning and/or regarding _____ _____, born on _____, and whose Social Security number is__ _____, for the following purpose(s):

___ Further mental health evaluation, treatment, or care
___ Rehabilitation program development or services
___ Treatment planning
___ Research
___ Other, specify: _____

_____

The information to be disclosed is as follows:

___ Intake and discharge summaries
___ Medical history and evaluation(s)
___ Mental health evaluations
___ Developmental and/or social history
___ Educational records
___ Progress notes, and treatment or closing summary
___ Other : _____

The purpose of the disclosure:

___ Legal ___ Referral ___ Care coordination
___ Discharge Planning ___ Other: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ___ Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer protected by federal privacy regulations.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of parent/ guardian/representative	Printed name/Relationship	Date
_____	_____	_____
Signature of witness	Printed name	Date