Authorization for **Use and Disclose of Protected Health Information (PHI)**

Katherine Ferrell, MA, LMHC of Seattle Compassionate Counseling

Client name: _____ Previous name: _____ Date of Birth: _____
Address: _____
Phone number: _____ Email: _____

I, _____, _____ hereby authorize the release of _____ health care information
(Name of client or representative) (Relationship to client) (Client/Child's/Other)

TO / FROM (circle one or both):
Name and Organization: Katherine ("Katie") Ferrell, MA, LMHC and Seattle Compassionate Counseling staff
Mailing Address: 1546 NW 56th Street #531, Seattle, WA 98107
Phone: 206-686-9390 Fax:

TO / FROM (circle one or both): _____
Address: _____ Phone: _____ Fax: _____

By signing this Authorization, I authorize the use and disclosure of all health information, including the following:

☐ All Health Care Information about client, including clinical records. This information may include, if applicable:

Yes	No	
☐	☐	Information about mental health diagnosis or treatment.
☐	☐	Information about diagnosis or treatment for alcohol or drug use, abuse, or dependence.
☐	☐	Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).
☐	☐	Information about diagnosis or treatment of Sexually Transmitted Disease(s) or Infections.

☐ Specific Health Information *including only*: _____

For the Purpose(s) of: ☐Continuity of care ☐ Client request ☐ Disclosure for legal purposes _____
☐In case of emergency ☐Other _____

This authorization ends: (check one box) ☐in one (1) year ☐ 90 days (if no other event)
☐when the following occurs: _____

I UNDERSTAND AND ACKNOWLEDLGE THAT: My records may contain information related to my mental health; my written consent is required to release any health care information related to testing, diagnosis, and/ or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and or drug and/or alcohol use unless otherwise allowed or required by law; this authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent; I may refuse to sign this authorization or revoke authorization in writing at any time, except to the extent that the action has already been taken in reliance of it; information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by this provider, office, or HIPAA regulation; and commencement, continuation, or quality of treatment will not be conditioned on whether I sign this document except insofar as PHI is necessary to assessment, report, or treatment contemplated by this authorization. However, failure to sign here may result in a denial of insurance benefits by your insurer. PHI may be conveyed in writing, fax, or verbal/telephone communication. Photocopy of this release has the same force and effect as the original. I have received a copy of my signed authorization. I hereby release the provider of my PHI from any and all legal liability that may arise from the use and disclosure of information as set forth in this Authorization.

_____ _____ _____
Signature of client or legally authorized representative Date Time

_____
Relationship if signed on behalf of the client by parent, legal guardian, personal representative, etc.