

Authorization to Disclose Personal Health Information

This is the statement of

Client Name	Address	Date of Birth
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which formally authorizes

Marie McNabb, MA, LMHC	2711 E Madison #209 Seattle, WA, 98112
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- Check all that apply:
- Provide Photocopies to
 - Obtain Photocopies from
 - Disclose Information to
 - Obtain Information from
 - Exchange Information with

the following person or organization:

Name	Address / Phone	Relationship
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Type of information

<input type="checkbox"/> Billing & Payment Information	<input type="checkbox"/> Dates of Attendance	<input type="checkbox"/> Brief treatment notes	<input type="checkbox"/> Assessment and/or Diagnosis
<input type="checkbox"/> Treatment progress	<input type="checkbox"/> Attendance	<input type="checkbox"/> Medical or health concerns	<input type="checkbox"/> Medication concerns
Other, please describe			

Purpose of this authorization:

Preferred form of exchange:

<input type="checkbox"/> Written	<input type="checkbox"/> Email	<input type="checkbox"/> Fax	<input type="checkbox"/> Verbal	<input type="checkbox"/> Other:
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Duration of this authorization:

<input type="checkbox"/> 3 Months from date signed below	From	To	<input type="checkbox"/> One Time Only
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This authorization is subject to revocation at any time, unless the information has already been disclosed/exchanged. If not previously revoked or if another date is indicated, this consent will terminate in ninety (90) days from the signature date.

Client Signature / Legal Representative	Date
Witness Signature	Relationship

CLIENT: _____