Ruth Graham, MA LMHC
Child, Adolescent, Adult & Family Therapist
206-605-0664 www.hopecounselingcenters.com
DBA Hope Counseling Centers

Authorization for Release of Information

Name of Client: ____ **Date of Birth:** __________________________
Address: ____ **City, State, Zip:** ______________________________
Phone Number: ____

☐ **I authorize Hope Counseling Centers to release information to:**

____
Name of Provider, Facility, or Family Member

____
Address

____
City, State, Zip Code

____
Phone #/Fax # (Include area code)

AND/OR

☐ **I authorize Hope Counseling Centers to obtain information from:**

____
Name of Provider, Facility, or Family Member

____
Address

____
City, State, Zip Code

____
Phone #/Fax # (Include area code)

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other (please explain):**
____
____

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)
☐ **Intake Documents** ☐ **Progress Notes** ☐ **Assessment Forms:** ______________________________
☐ **Diagnostic Impression** ☐ **Discharge Summary** ☐ **Treatment Plans**
☐ **Treatment Summary** ☐ **Proof of Attendance / Treatment**

☐ **Other: (**please describe) ____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**
☐ When the requested information has been sent/received.
☐ 90 days from this date. ☐ Other: ____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.
My authorization will expire:
☐ 30 days after I am no longer receiving services from Hope Counseling Centers.
☐ One year from this date. ☐ Other: ____________________________________

I understand that:
- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to Hope Counseling Centers, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Client or Representative: ____ Date: __________________
Printed name of Client or Representative: ____
Relationship to Client (*if requester is not the client)*: ☐ Parent ☐ Legal Guardian ☐ Other: ____________________
Patient or Representative has been provided a copy of this authorization: ____________________________________
Staff member providing copy *Date*