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Authorization to Release Confidential Records and/or Information

I hereby authorize _____, to release information about
_____, born on _____

and whose Social Security number is _____, for the following purpose(s):

- Further Mental Health Evaluation, Treatment or Care Treatment Planning
 Coordination of Care Consultation Treatment Monitoring
 Research Other (specify): _____

The following records and/or information marked by a check in the boxes below may be disclosed; and the items not to be released or disclosed have a line drawn through them.

- Intake and Discharge Summaries Medical History & Evaluation(s)
 Mental Health Evaluation(s) Developmental and/or Social History
 Progress Notes and Treatment Summary Billing Records
 Diagnosis Only Dates of Treatment & Summary of Progress
 HIV-related Information and Drug / Alcohol Information
 Other (specify): _____

It is my wish that this consent for disclosure will expire:

- _____ Ninety (90) days after the date it is signed.
(expiration)

I am aware that information from my record is confidential and is protected by Federal and State Law. Federal (42CFR part 2) and State (WAC 240) regulations prohibit all parties receiving this confidential information from making any further disclosure of these records without my specific consent, or as permitted by these regulations.

I understand that transmittal of this completed form acknowledges to the recipient that I am a client of _____, and agree to this disclosure.
(name of clinician)

(signature of client)

(printed name)

(date)

(signature of parent / guardian)

(printed name)

(date)