Reid Stell Counseling
Authorization to Release Confidential Information

Client Name: _____ **Date of Birth:** _____

PROTECTED HEALTH INFORMATION IS TO BE SHARED BETWEEN THE FOLLOWING ENTITIES:

Name: _____
Organization: _____
Address: _____
_____
City *State* *Zip*
Phone: _____
Fax: _____

Reid Stell
Reid Stell Counseling
14535 Bel-Red Rd, Suite B-202
Bellevue, WA 98007

Ph: 206.457.3038
Fax: 206.858.9206

Purpose of Disclosure:

_____
_____
_____

Specific Information to be Disclosed:

_____
_____
_____

Specify Dates of Service to be Released: From: _____ To: _____

Expiration Date or Event: _____

Specific Authorization:

I understand that my records may contain information regarding testing, diagnosis and/or treatment of HIV/AIDS or other sexually transmitted diseases. I give specific authorization for these records to be released.
(Per RCW 70.24.105). Yes _____ No _____ Client Initials _____

I Understand:

1. My records are protected under the Federal and State statutes and cannot be disclosed without written consent unless otherwise provided for in the regulations.
2. I may revoke this consent, in writing, at any time except to the extent that action has already been taken.
3. This authorization for release of healthcare information expires in 90 days, unless sooner revoked by me in writing.
4. There may be charges associated with your request for records. Such charges shall not exceed the amounts allowable under RCW 70.02.
5. That, when necessary, portions of my records may be faxed.
6. A photocopy of this authorization shall have the same effect as the original.
7. My records contain mental health information and I give my specific authorization for these records to be released.
8. My records may contain information regarding diagnosis and/or treatment for drug or alcohol abuse. I give my specific authorization for these records to be released.

Any minor children thirteen (13) years or older has all the rights provided by Chapter 275-56 WAC to clients receiving outpatient services. Therefore, these minor clients must sign authorization for release of client information. In addition, it is the policy of Reid Stell Counseling to require the signed consent of a legal guardian in addition to that of the minor client.

Signature of Client: _____ Date: _____

Signature of Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

All sections on this consent form must be completed for this release to be valid.