Authorization to Release Confidential Information

Client Name:_____ Date of Birth: _____

Address: _____

Information to be released by:	Information to be released to:
Name:_____	Yvonne Clayton, MA, LMHC
Organization:_____	Yvonne Clayton Counseling, LLC
Address:_____	8752 122nd Avenue NE
City/State/Zip:_____	Kirkland, WA 98033
Phone: _____	Phone: (425) 941-3359

_____(Client initials) This Authorizes Mutual Exchange of Information Between the Above Entities

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 Summary
- □ 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:

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

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 Yvonne Clayton, MA, LMHC and agree to this disclosure.

_____

(signature of client) (printed name) (date)

_____

(signature of client) (printed name) (date)