

Release of Information for Disclosure of Mental Health Treatment Information

I, _____ (full name of client/ legal guardian), on behalf of
_____, (self/ full name of client) whose date of birth is _____, authorize Brianna
Longwell Psychotherapy with Associates in Mental Health to disclose to, exchange, and/or obtain information from:

Description of Information to be disclosed (client initial by each item):

_____ All information	_____ Medical Information
_____ Assessment	_____ Treatment Plan or Summary
_____ Diagnosis	_____ Progress in Treatment

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Brianna Longwell at briannalongwellpsychotherapy@gmail.com or 103 E Holly St. #202 Bellingham, WA 98225.

Expiration

This release is valid for (check one): ☐ 90-days ☐ one-year ☐ cessation of therapy services

Form of Disclosure and Redisclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate (verbal, in writing, electronically, etc.).

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

Signature of Client

Date

Signature of Parent/Guardian/Personal Rep.

Date

Signature of Therapist

Date