SUSA HOLT INTEGRATIVE COUNSELING, PLLC 425-775-4059, Ext 704

Authorization to Release Information

To facilitate informed services, I _____ (DOB: _____) hereby authorize the mutual release/exchange of information concerning:

_____ Information Regarding Previous Treatment _____Progress in Treatment

_____ Medical Information _____ Evaluation Results

_____ Mental Health Information _____ Other: _____

_____

between **Susa Holt Integrative Counseling** and

Person: _____

Organization: _____

Address: _____

Phone: _____ Fax: _____

I understand that records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems are protected under federal confidentiality regulations (42 CFR, Part 2 – Alcohol and Drug) and cannot be discosed without my written consent. I also consent to the release of that information. _____ (client initial)

I understand that my records may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or sexually transmitted diseases. I consent to the release of that information. _____ (client initial)

Other parties receiving this information are prohibited from re-disclosing these records, unless expressly permitted by my written consent, unless disclosure is otherwise permitted by federal regulations.

This consent will expire upon the completion of treatment or any other agreed upon date.

Client signature: _____ Date: _____