Playful Healing Counseling, LLC

400 E Evergreen Blvd, Suite 315, Vancouver WA 98660 * (360) 836-1297

Authorization to Use and Disclose Protected Health Information

_____ _____
Client Name Date of Birth

Release By:

I authorize:
- □ Playful Healing Counseling, LLC
- □ Other health/service entity (name/address of recipient): _____

To use and disclose a copy of the health/service information described below for the above-named client.

Health/Service information is to be received and used by:

- □ Playful Healing Counseling, LLC
- □ Other health/service entity (name/address of recipient): _____

____ Client Initials This authorizes mutual exchange of information between the above entities

---

Specific Purpose(s) of Disclosure:

By my signature below, I hereby authorize the Provider to use or disclose to the Recipient my Protected Health Information(PHI) for the term of this authorization for the following specific purpose(s): (At the request of the client" is sufficient if the client is initiating this Authorization)

- □ At the request of the client or legal guardian if the client is under the age of 13.
- □ Coordination of care/treatment planning
- □ Other _____

Description of information to be used and/or disclosed:

The following items must be initialed to be released: (Initial all that apply)

_____ Assessment/Intake Summary
_____ Treatment/Service Plan
_____ Medical records, including prescribed medications or psychiatric records
_____ Educational testing and school reports
_____ Legal reports/court documents
_____ Safety/Crisis Plan
_____ Treatment Summary
_____ Other (specify):

AIDS/HIV/STD's
□YES □NO □N/A

Drugs/Alcohol
□YES □NO □N/A

Client Initials

I understand that my records may contain information regarding testing, diagnosis, and/or treatment of HIV/AIDS, or sexually transmitted diseases. I give my specific authorization for these records to be released. (Per RCW 70.24.105)

My records may contain information regarding diagnosis and/or treatment for drug and alcohol abuse. I give my specific authorization for these records to be released.

Notices:

1. I understand that, if the recipient of this information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR part 2 and 45 CFR parts 160 and 164 or state law may prevent the recipient from re-disclosing this information.

2. I may refuse to sign this authorization and I understand that doing so will not adversely affect my ability to receive treatment or to obtain payment for my treatment. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for mental health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

3. I understand that I may revoke this authorization at any time by notifying Playful Healing Counseling of the above named entity on its designated form. However, any such revocation will not apply to any activity undertaken based on this authorization. To revoke this authorization, it must be in writing and submitted to Playful Healing Counseling. Unless cancelled earlier by me, this authorization will expire 1 year from signature date. A copy or FAX shall be considered valid in lieu of the original.

4. I understand that I may inspect or request copies of information disclosed by this authorization.

5. A copy of this authorization has been offered to the client.

    ☐ Accepted

    ☐ Declined

Unless revoked, this authorization is good for 1 year from the signature date below, or the following time period:
Beginning Date:_____Ending Date (Expiration Date):_____

I have read and understand the terms of this authorization. I have had the opportunity to ask questions about the use and disclosure of my Protected Health Information. Any minor child thirteen (13) and older has all the rights provided by Chapter 388-865 WAC to clients receiving outpatient services. Therefore, these minors must sign authorization for release of client information.

_____

Signature of Client or legal guardian/representative Relationship to Client Date

_____

Print Name