Stillwater Counseling P.S.
Bill Bedell MAC LMHC LH 60017477
253-334-5147

<u>Consent to Disclosure of Information and Records</u>

I,____ (Date of Birth:____________) hereby authorize ______________________________________ to release my records and reports relating to my appointments beginning with my first appointment on __________________________________. This information is to be given to:___________________________________; for the following purpose, use or need:

- ☐ Coordination of treatment
- ☐ Provision of information to other professionals
- ☐ Other ____

The following information from my records may be disclosed:

- ☐ General Protected Health Information (PHI) (Demographic data, dates of service, diagnosis, psychological evaluation, treatment plan, global assessment of treatment progress)
- ☐ Psychotherapy Notes
- ☐ Verbal Exchange of PHI

I understand that this authorization may be withdrawn by me at anytime. Revocation of this authorization will not affect any information already released. I hereby certify that I am 18 years of age or older. Unless this form is previously revoked in writing, this release of information will remain in force until six (6) months from date of signature.

____ ________________________
Signature of Client Date

____ ________________________
Witness Date

<u>Consent By Person Other Than Client</u>

If client is under 18 years of age or otherwise unable to consent, the following must be completed:

I,____ hereby certify that I am the

___________________________________of the client; that the client is unable to consent because he/she is a

minor,_____________years of age or because: ____.

____ ______________________
Signature of Parent, Guardian, etc. Date

____ ______________________
Witness Date