

VANCOUVER GUIDANCE CLINIC, P.S.

3112 MAIN STREET

VANCOUVER, WA. 98663

360-694-2016 FAX-360-694-8990

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

CLIENTS NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HEREBY GIVE MY PERMISSION TO VANCOUVER GUIDANCE CLINIC

TO RECEIVE AND EXCHANGE VERBAL WRITTEN CLINICAL/MEDICAL INFORMATION OR OTHER

INFORMATION WITH:

INDIVIDUAL/AGENCY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TITLE/RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TYPE OF INFORMATION:

☐MENTAL HEALTH ☐ALCOHOL OR OTHER DRUGS ☐BOTH ☐MEDICAL ☐OTHER

TIMEFRAME: (MONTH/DATE/YEAR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ENDING ON(MONTH/DATE/YEAR):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PURPOSE OF RELEASE:

(MUST BE COMPLETED AND INITIALED BY CLIENT OR PARENT/GUARDIAN):

☐AID/ASSIST BY ABOVE NAMED AGENCY

☐CONTINUED CARE BY THE RECEIVING FACILITY/DOCTOR/CLINICIAN

☐ASSESSMENT/TREATMENT

☐COORDINATION OF TREATMENT WITH ANOTHER AGENCY/FACILITY

☐CLAIMS SETTLEMENT WITH INSURANCE COMPANY

☐LEGAL PROCEEDINGS OR ADVICE/COURT DATE

☐OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFORMATION TO RELEASE:

(PLEASE NOTE ANY EXCEPTIONS TO YOUR PERMISSION BELOW):

☐ASSESSMENT/EVALUATION ☐CLIENT PLAN/TREATMENT PLAN ☐CONSULTATION REPORT(S)

☐DATES OF HOSPITALIZATION ONLY ☐DISCHARGE SUMMARY ☐EDUCATIONAL TESTS/REPORTS

☐HISTORY & PHYSICAL EXAM ☐PROGRESS NOTES ☐MEDICAL RECORDS

☐PHYSICIAN’S ORDERS ☐PSYCHOLOGICAL TEST/RESULTS ☐OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ALL INFORMATION

THIS AUTHORIZATION FOR RELEASE OF INFORMATION IS TO REMAIN VALID UNTIL PERMISSION IS WITHDRAWN OR FOR A PERIOD OF 1 (ONE) YEAR.

CLIENT/PARENT/GUARDIAN’S SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MINOR CHILD D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vancouver Guidance Clinic. P.S. is upheld to following the Washington HIPPA Laws to the fullest.