Authorization to Disclose (Release) Protected Health Information

All Seasons Counseling Mark Travis, MA, M.DIV, LMFT License #LF 61064085
Bainbridge Island WA 98110
Cell 206-472-0535 / Fax 206-472-0535
mark@allseasonscounseling.biz / www.allseasonscounseling.biz

I _____ D.O.B _____

Authorize Mark Travis from All Seasons Counseling, to exchange information with

Name/Organization _____ Phone #_____

Specific Nature of Information to be released:

__ Any or all the following

__ Information related to payment.

__ only listen to parent(s)/guardians or others concerns/thoughts.

__ Presenting complaints / issues

__ Diagnosis and/or assessment results, treatment plans and goals

__ Summary of treatment plan and goals

__ Response to treatment / progress

__ Recommendations / suggestions

__ Substance use / abuse

__ Copies of clinical records

Other: _____

I/We may revoke this authorization at any time in writing. If I/We revoke this authorization, it will not affect any actions already taken based upon this authorization.

I/We have the right to a copy and inspect information being disclosed.

I/We acknowledge that this authorization and intent was fully explained to Me/Us and is signed by My/Our free will.

This authorization will automatically expire one year from date signed, unless otherwise specified. _____ days.

Signature: _____ Date: _____

Printed Name: _____

*Name of Parent(s) or Guardian(s) if client is uder the age of 13

Signature_____ Date:_____

Printed Name: _____

Signature: _____ Date:_____

Printed Name: _____