Authorization for Release of Information

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____, authorize Canyon Lake Family Counseling Center, its staff and providers to disclose to and/or obtain from:

_____ the following information:

Description of Information to be disclosed

(Patient/Client should check each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services, create safety plans and/or complete home studies.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Canyon Lakes Family Counseling Center, PLLC, 3801 S Zintel Way #120, Kennewick, WA 99337. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires one year from the date signed.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

Signature of Witness Date

Canyon Lakes Family Counseling Center * 3801 S Zintel Way #120 * Kennewick, WA * 99337 *
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