Bayside Therapy Associates, LLC
12 Bellwether Way Suite 220, Bellingham WA 98225 ♦ phone (360) 734-7310 ♦ fax (360) 647-8336

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Client Name: _____ Birth date: _____/_____/_____ SS#:_____

Previous Name(s): _____ Address: _____

Bayside Therapy Associates Treating Provider:_____

Information is to be disclosed to ☐ and/or received from ☐ :

Name of Person/Agency: _____

Address: _____ Phone: (_____)_____Fax: (_____)_____

For purposes of: _____Evaluation _____Treatment _____Forensic Assistance ____Other: _____

I authorize Bayside Therapy Associates to release my:

_____ Medical records relating to the following treatment, condition or dates of treatment:_____

_____ Coordination of Care

_____ All Medical Records

_____ Other: _____

I understand that my express consent is required to release any information relating to testing, diagnosis and/or treatment for psychiatric disorders/mental health, drug and/or alcohol use, sexually transmitted diseases, or HIV (AIDS virus). If I have been tested, diagnosed or treated for psychiatric disorders/mental health, drug and/or alcohol use, sexually transmitted diseases, or HIV (AIDS virus), you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

The authorization of this release begins: _____ and expires: _____
Date Date

This consent may be voided in writing at any time except to the extent that action has already been taken. Photocopies and facsimiles of this authorization and signature are to be considered as valid as the original.

_____ _____
Signature of Client Date

Parent/Guardian signature is required for all children under age 13. For children age 13 and over, we encourage the parent/guardian to sign, but it is not required. *I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.*

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

[Signature Update for Release Extension]

_____ _____ to _____
Signature of Client/Parent/Guardian or Authorized Representative Beginning Date End Date