Pamela W. Webster, LICSW, LCSW
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Mail: 13023 NE Hwy 99, Ste. 7-233, Vancouver, WA 98686
(360) 760-4041 · (360) 760-4218 fax

Authorization to Release
Mental Health Treatment Information

I, ____, Date of Birth ________________________,

authorize Pamela W. Webster, LICSW, LCSW to disclose to and/or obtain from:

____ the following information:
Name of Person or Title of Person or Organization

Description of Information to be Disclosed:

(Patient/Client should initial 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. (This information will NOT be used for marketing purposes, sale of information, or research.)

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Pamela W. Webster, LICSW, LCSW at 13023 NE Hwy 99, Ste. 7-233, Vancouver, WA 98686. 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

This authorization expires one year from the effective date unless revoked earlier.

Conditions

I further understand that Pamela W. Webster, LICSW, LCSW will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

____

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Form of Disclosure

Unless I have specifically requested in writing that the disclosure be made in a certain format, Pamela W. Webster, LICSW, LCSW reserves the right to disclose information as permitted by this authorization in any manner that she deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient (e. g., client, physician, agency) and the protected health information will no longer be protected by the HIPAA privacy regulations unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records if I wish to have a copy.

____ ____________________
Signature of Patient/Client Date

____ ____________________
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

____ ____________________
Pamela W. Webster, LICSW, LCSW Date