Pamela W. Webster, LICSW, LCSW
419 E. Cedar Ave., Suite 205, La Center
Mail: 13023 NE Hwy 99, Ste. 7-233, Vancouver, WA 98686
(360) 760-4041 · (360) 760-4218 fax

Authorization to Release
Substance Abuse 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
_____ Toxicology Reports/Drug Screens

_____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:

_____

_____

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