ASPENTREE COUNSELING
& HYPNOTHERAPY
9481 Silverdale Way #209, PO Box 1734, Silverdale, WA 98383
Phone #: (360) 920-7047 FAX #: (360) 286-2369

ACH STAFF USE ONLY

_____
Staff assisting in form completion
☐ **File only (no action required)**

CLIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please allow up to fifteen (15) days for processing.
Failure to complete EACH section (a-i) will render this authorization invalid, and it will not be processed.

(a) Client Name: **D.O.B:**

(b) I hereby authorize Aspentree Counseling & Hypnotherapy to:

(To release records AND to request records, please complete two authorization forms. Verbal exchange is included when checking the middle or bottom box.)

☐ **Exchange information VERBALLY via phone/personal contact {*Indicate what kind of information you will be discussing in section (c)}***

☐ **Copy my ACH medical records and send / release them TO**

☐ **Request medical records FROM the listed provider and have them sent to ACH**

***Person/Provider:** _____
Relationship to Client: _____
***Street Address:** _____
***City, State, Zip:** _____
Phone Number: _____
Fax Number: _____

** Must list COMPLETE address INCLUDING VERBAL requests*

(c) Please check (initials are preferred) all records that you would like released to or requested from (including verbal) an outside source:

____ ☐ Intake / Treatment Summaries / Plans / LOC
____ ☐ Medication Records & Medication Assessments
____ ☐ Phone Contact
____ ☐ Progress Notes / Reports
____ ☐ Crisis Plans
____ ☐ Laboratory / X-Ray / EKG Reports
____ ☐ Psychological Testing Assessment
____ ☐ Psychiatric Evaluation Records
____ ☐ Contact with School Teachers
____ ☐ Termination/ Discharge Summary
____ ☐ DSHS Psychiatric/Psychological Eval
____ ☐ Academic Testing / Classroom Reports
____ ☐ Probation / Parole Reports
____ ☐ Financial Information
____ ☐ Hospital Admit / Discharge Information
____ ☐ Social Worker's Reports
____ ☐ Contact With School Counselors
____ ☐ Other: _____

(d) Authorization Expiration (45 CFR 164.508c & RCW 70.02.030 #f *effective July 2005*):

☐ **ACTIVE ACH CLIENTS ONLY:** This authorization will expire one (1) year from the signature date **OR** until such time that I am no longer receiving active mental health services from Aspentree Counseling & Hypnotherapy, **whichever event occurs first.**

☐ This authorization is valid only until the date specified. Expiration Date *(not to exceed one year from signature date):* _____

****If none of the items in this section are marked when submitted to ACH Medical Records, this authorization automatically expires 90 days from the signature date.**

(e) Disclosure of Information is for CONTINUITY OF CARE unless otherwise specified below:

☐ Legal ☐ Financial ☐ Personal Records ☐ Client's Request ☐ Other: _____

Specific Authorizations

(f) I understand that my records may contain information regarding psychiatric/mental health diagnosis and treatment, drug and/or alcohol abuse (Per 42CFR, Part 2), the testing, diagnosis, or treatment of HIV/AIDS and/or sexually transmitted diseases (Per RCW 70.24.105). I give my specific authorization for these protected records to be released. {If you do not want these records released, you must complete section (g)}

(g) ☐ I DO NOT want the following information to be released (If nothing is specified, all information will be included):

(h) HIPAA: 1) I understand that I have the right to refuse to sign this authorization; however, my failure to complete this authorization will result in information not being disclosed or obtained. 2) Aspentree Counseling & Hypnotherapy is prohibited from conditioning treatment, payment, enrollment, or eligibility for benefits on my agreement to sign this authorization. 3) Once disclosed to the above listed person/provider, my information may potentially be re-disclosed by the receiving party and may no longer be protected by law. 4) I understand that I may revoke this authority at any time, except to the extent that action has already been taken. To revoke this authorization it must be in writing and submitted to Aspentree Counseling & Hypnotherapy.

(i) Client Signature: **Date:**

(j) Representative Signature: _____ **Date:** _____
(Client must sign own consent if 13 years old or older)

Relationship to Client: _____

(k) Witness Signature: _____ **Date:** _____

A copy or FAX of this ROI shall be considered valid in lieu of the original. A charge for the reproduction (copy) of medical records may be assessed.