INTEGRITY COUNSELING

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____

Client Name (Please Print) Date of Birth (MM/DD/YY)

I hereby freely and voluntarily authorize Olya Pavlishina, LMFT to …

____ Release/disclose records of my health information to:

____ Obtain records of my health information from:

_____

Individual, Title, Organization

_____

Address Phone

**Health Information includes medical information about the client collected from the client, created by the Provider, or received by the Provider from another health care provider or health plan. Health information may relate to past, present, or future physical or mental health conditions. Health information may also include information related to payment for health care services.*

SCOPE OF USE OR DISCLOSURE. The Health Information that may be used or disclosed though this authorization is as follows (check only one box):

□ All Health Information about me, including clinical records, created or received by the Provider. This information may include, if applicable:

- Information about mental health diagnosis or treatment including psychotherapy notes.
- Information about diagnosis or treatment for alcohol or drug abuse.
- Information about HIV/AIDS Testing or Treatment (including the fact that and HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative.
- Information about diagnosis or treatment of Sexually Transmitted Disease(s).

□ All Health Information about me as described in the preceding checkbox, excluding the following: _____

□ Specific Health Information including only:
_____

□ Other: _____

TERM: This Authorization will remain in effect for ninety (90) days or until _____ (must be less than 90 days).

SPECIFIC PURPOSE(S) OF DISCLOSURE: By my signature below, I hereby authorize the Provider to use or disclose to the Recipient my Health Information for the term of this Authorization for the following specific purpose(s): ("At the request of the client" is sufficient if the client is initiating this Authorization).

□ At the request of the client or legal guardian if consumer is under age 13
□ Coordination of care/treatment planning
□ Other: _____

OTHER IMPORTANT INFORMATION:

- I understand that once the Provider discloses my health information to the Recipient, the Provider cannot guarantee that the Recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my Health Information.

- I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of the treatment provided to me.

- I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Provider at the address listed below. The revocation will be effective immediately upon the Provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before it receives my written notice of revocation.

I may contact Olya Pavlishina, LMFT by telephone at (360) 356-8756.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my Health Information. By my signature below, I hereby knowingly and voluntarily authorize the Provider to use or disclose my health information in the manner described above.

_____ _____
Signature of Client (13 years or older) Date

If the client is under 13 years of age, or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____
Signature of Parent or Legal Guardian | Description of Authority | Date