Megan Fisher Counseling, LLC

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Authorization to Disclose Health Information

I, _____ DOB: _____

Authorize Megan Fisher, MA, LMHC to disclose, obtain, or exchange information about me and/or my therapeutic process with:

_____
Name of person/organization

_____
Address

_____
Phone

Specific information to be released or exchanged will pertain to or include:

___Evaluation and Treatment ___Current Medications ___Therapeutic Progress ___Discharge Planning

___Other (Specify)_____

The above information will be used for the following purpose(s):

___Continuity of Care ___Treatment Planning ___Discharge Planning ___Coordinate treatment services

___Other (Specify)_____

Means of disclosure (check all that apply):____Written ___Oral ____Electronic ____Other (specify):_____

I understand my records are protected under Washington state laws pertaining to confidentiality and cannot be disclosed without this written consent unless otherwise provided for in the regulations. I also understand I may revoke in writing this consent at any time per RCW 70.02.040.

Date or event upon which this authorization will expire:_____
I understand if I do not note a date or event, then this authorization will expire one year from date signed below.

Signature of Client_____ Date: _____

Client Name: _____

Signature of Witness_____ Date: _____