AUTHORIZATION TO RELEASE INFORMATION

Behavioral Healthcare Incorporated

1812 Sumner Ave Ste I, Aberdeen, WA 98520
Please respond by secure FAX to (360) 532-0061

I, **(print name)** ______________________________,DOB____/___/_________ (hereinafter "Patient") hereby authorize **Behavioral Healthcare Incorporated**, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, **OR** Minor child for whom I am parent/legal guardian **OR** adult client for whom I am POA/Legal Guardian including, but not limited to, therapist's diagnosis of Patient.

Name and Address of Facility or Party releasing or requesting from

____

____

Information to be disclosed:	□ Billing/Scheduling **Only**
Please check one	□ Treatment
	□ Everything
	□ Other: ______________

DISCLOSURES REQUIRING SPECIAL AUTHORIZATION:
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment of: *(Check all that apply)*

□ HIV/AIDS Virus
□ Sexually Transmitted Diseases
□ Mental Health/Psychiatric Disorders
□ Drug, alcohol abuse/treatment

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Behavioral Counseling Associates to be effective.

This authorization shall remain valid until: ***Date-*** **______/_____/________ OR**
90 Days from date of signature, whichever date is sooner (RCW 70.02.030(7)). . A copy or fax of this document shall be considered valid in lieu of original.

Patient's signature: X________________________ _____Date:___________________