CONFIDENTIAL

Elizabeth Nyblade, Ph.D. • Clinical, School and Forensic Psychologist
1313 East Maple Street, Suite 214 • Bellingham, WA 98225
Phone: (360) 647-8295 • FAX: (360) 647-8296 • e-mail:
enyblade@mindingyourspirittogether.com

Authorization to Release Health Care Information and Records

Patient's Name:_____ **Date of Birth:**_____

S.S.N.:_____ **Previous Names:**_____

I request and authorize Dr. Elizabeth Nyblade to release and/or obtain health care information and records of the patient named above to/from:

Name:_____
Address:_____
City, State, Zip:_____

Extent and nature of disclosure:	**Purpose of this disclosure:**
☐ alcohol/drug evaluation	☐ coordinating service delivery
☐ current psychiatric status	☐ assisting in diagnosis and treatment
☐ psychiatric history/evaluations	☐ assuring continuity of care
☐ hospital records/history & physical/discharge	☐ facilitating resident placement
☐ progress notes	☐ reporting to probation officer or court
☐ individual treatment plan	☐ ITA investigation/coordination
☐ treatment summary	☐ determine program eligibility
☐ medication records/laboratory reports	☐ educating family member(s) about mental illness
☐ school history (academic, social/behavioral)	☐ referring to another agency/program
☐ medical history including HIV/AIDS	☐ Other _____
☐ Other	☐ verbal disclosure ☐ written disclosure

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for psychiatric disorders/mental health, drug and/or alcohol use, or HIV (AIDS virus), or sexually transmitted diseases. If I have been tested, diagnosed, or treated for psychiatric disorders/mental health, HIV (AIDS virus), sexually transmitted diseases or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

<u>Required Signatures</u>: Under 12 years old (parent/guardian only), 13-17 years old (parent/guardian and client), 18 years old and older (client only)

_____
Signature of Patient **Date Signed**

_____
Signature of Patient/Representative/Parent **Date Signed**

_____
Signature of Patient/Representative/Parent **Date Signed**

This authorization expires 90 days after the date it is signed with respect to any health care information which is disclosed.