RELEASE OF INFORMATION:
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

LITTLE BIRD PSYCHOTHERAPY, P.S., INC

Client Information *Please print legibly.*	Name*_____ Date of Birth*_____ Other Names Used:_____ Phone #:_____ Parent/Guardian/Legal Representative Name (where applicable)_____
Health Care Provider, Agency, or Emergency Contact With **whom** may Little Bird Psychotherapy (LBP) share/ receive your information?	_____ Name of Clinic/Physician/Provider, Person, Insurer, Agency* (e.g. Dr. John Smith, Children's Hospital) _____ _____ _____ Relationship to Client Phone Number Fax Number _____ Address (street, city, state, zip code) *Required Field
Communication ***How** will LBP share your information?*	___Sending/requesting physical copies of your medical record (via mail or fax) to the person identified above ___Verbal communication about your care and treatment to the person identified above **You may choose both options! Confused about the best option to choose? Reference the FAQ.**
Information to be Released ***What** is to be released?* **Please check all that apply.**	I authorize Little Bird Psychotherapy to release ___ALL information and records pertaining my treatment, including **all** items listed below: ___Intake Evaluations/Diagnostic Assessment ___Treatment Plans ___Nutritional Documentation ___Discharge Summaries ___Medical Documentation/Labs ___Genetic Information ___Substance Use Disorder Records ___HIV/AIDS Records ___Individual Therapy Documentation/Progress Notes ___ Psychiatric Documentation ___Administrative Records (e.g. appointment listings, billing) ___Other (please specify)_____
Purpose of the Release of Information **Why** is the release needed?	___Client Request ___Coordination of Care ___Disability or Other Benefits ___Discharge and Continuation of Care ___Litigation/Legal Purposes ___Other (please specify)_____

Statement of Authorization: I understand that:

- I may revoke this consent at any time, except to the extent that Little Bird Psychotherapy (LBP) has already acted in reliance on it, by providing oral or written notice to LBP at the address noted in the Notice of Privacy Practices. **After one year, this consent automatically expires.**
- I have been informed what information will be released, its purpose and who will receive the information, and I may inspect or copy the protected health information to be used or disclosed under this authorization per applicable state and federal laws.
- I understand that any substance use disorder treatment and diagnosis records are protected under federal regulation 42 CFR Part 2 and disclosure is allowed only with this specific authorization, except in limited circumstances as stated in LBP's Notice of Privacy Practices and Informed Consent.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from substance use disorder records. However, HIPAA requires LBP to notify me that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA.
- I understand that I may refuse to sign this authorization. LBP will not condition treatment, payment, enrollment, or eligibility for services based on whether I sign this authorization.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM AND AUTHORIZE LITTLE BIRD PSYCHOTHERAPY TO RELEASE THE ABOVE SPECIFIED INFORMATION TO THE PARTY IDENTIFIED ABOVE FOR THE REASON IDENTIFIED ABOVE.

Client Signature* Parent/Guardian/Representative Signature **Date**

*Age of consent for **mental health records** is 13 years old in the state of Washington, clients 12 years old and younger must have Parent/Guardian consent.

*Age of consent for **substance abuse records** is 12 for outpatient, 18 for residential in the state of Washington.

Legal Representative (where applicable): I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.

Legal Guardian/Representative Signature Relationship to Client/Legal Authority **Date**