MINDSOURCE CENTER LLC

27023 164th Ave SE, Suite 109 Covington, WA 98042
253-639-7146 Fax: (253) 639-7145 **Email: help@mindsourcecenter.com**

Authorization to Use and Disclose Health Care Information

Client name: _____Date of birth: _____
Previous name or Parent/Guardian name if client is a minor child:_____

Please release health care information to:
Name/Title:_____Organization:_____
Address/Phone:_____

By signing this Authorization, I authorize _____(MindSource Center therapist) to use or disclose the following health information: (*check only one box*):

☐ All Health Information about me, including my clinical records, created or received by my MindSource Center therapist. 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 an 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*:_____

For the Purpose(s) of: _____
This authorization ends: (check only one box) ☐ in 90 days ☐ when the following occurs:
_____

Other Important Information
I may refuse to sign or cancel this Authorization at any time, in writing, as allowed by law. This will not affect any actions already taken by my MindSource Center Therapist in reliance upon my original request. There are three ways to cancel this Authorization:

1) Sign and date a revocation form. This form is available from my MindSource Center therapist, or
2) Write, sign and date a letter to the provider listed above to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

My cancellation or refusal to sign this Authorization will not affect the commencement, continuation, or quality of my MindSource Center Therapist's treatment of me. Once my therapist gives out the information, we have no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

I hereby release MindSource Center and its representatives from any and all legal liability that may arise from the use and disclosure of information as set forth in this Authorization.

_____ _____ _____
Signature of client or legally authorized representative Date Time

_____
Relationship if signed on behalf of the client by parent, legal guardian, personal representative, etc.

To request this information in an alternative format, please contact MindSource Center, 253-639-7146.
We will work with individuals requesting alternate formats, to ensure it is effective.