BAKER
FAMILY THERAPY
BOBBIE BAKER, MA, LMFT, RPT
4000 AURORA AVE. NORTH, SUITE 224
SEATTLE, WASHINGTON 98103

Authorization to Use and Disclose Protected Health Information (PHI)

Client name: _____ Date of Birth: _____

Address: _____

Phone number: _____ Email: _____

I, _____, _____ hereby authorize the release of _____ health care information
(Name of client or parent/guardian) (Relationship) (Child's)

TO/FROM: (circle one or both) Name and Organization: _____

Email:_____ Address: _____

City, State: _____ Zip Code: _____ Phone: _____

TO/FROM: (circle one or both)

Bobbie Baker, LMFT, RPT 4000 Aurora Ave. North Seattle, WA 98103 bobbie@bakerfamilytherapy.net 206.660.9562

By signing this Authorization, I authorize the use and disclosure of all health information, including the following:

☐ All Health Care Information about client, including clinical records. This information may include, if applicable:

Yes	No	
☐	☐	Information about mental health diagnosis or treatment.
☐	☐	Information about diagnosis or treatment for alcohol or drug use, abuse, or dependence.
☐	☐	Information about diagnosis or treatment of Sexually Transmitted Disease(s) or Infections.
☐	☐	Information about HIV/AIDS Testing or Treatment

☐ Specific Health Information *including only*: _____

For the Purpose(s) of: ☐ Continuity of care ☐ Client request ☐ legal purposes or procedures
☐ Other _____

This authorization ends: (check one box) ☐ in one (1) year ☐ 90 days (if no other event) ☐ Completion of treatment
☐ when the following occurs: _____

I UNDERSTAND AND ACKNOWLEDLGE THAT: My records may contain information related to my mental health; my written consent is required to release any health care information related to testing, diagnosis, and/ or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and or drug and/or alcohol use unless otherwise allowed or required by law; this authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent; I may refuse to sign this authorization or revoke authorization in writing at any time, except to the extent that the action has already been taken in reliance of it; information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by this provider, office, or HIPAA regulation; and commencement, continuation, or quality of treatment will not be conditioned on whether I sign this document except insofar as PHI is necessary to assessment, report, or treatment contemplated by this authorization. However, failure to sign here may result in a denial of insurance benefits by your insurer. PHI may be conveyed in writing, fax, or verbal/telephone communication. Photocopy of this release has the same force and effect as the original. **I have received a copy of my signed authorization.** I hereby release the provider of my PHI 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 Relationship to client Date