Family Therapy & Recovery, P.S.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Name	**DOB**

For the purpose of an exchange of information by: **Phone- Fax -Letter -Email -Face to Face**

Family Therapy & Recovery Address: 15 S. Grady Way Suite 249 Renton, WA 98057 Phone: 253.220.9452 Fax: 253.270.2236 Attn:_____	**Disclose ___ Receive ___ Exchange ___** **Person/Facility**: _____ Address: _____ _____ Phone:_____ Fax:_____

I authorize to disclose / Exchange specified confidential medical, psychiatric (including alcohol and/or drug), HIV/AIDS test results or diagnosis, and / or treatment information during the course of my therapy to and from the aforementioned parties. _____ (IN)

Initial each item applicable to request

_____	Acknowledgement of Patient's Presence in Facility **ONLY-** ***If first line checked and initialed STOP-do not check or initial anything further**
_____	Diagnostic Assessment, Impression, Treatment Recommendations
_____	Dates of Attendance at FTR and/or other treatment programs (CD or MH)
_____	Attendance at Self-help Support Meetings and/or Treatment Program
_____	Reports on Patients progress Towards Treatment Objectives
_____	Discharge Summary and Aftercare Plan for CD or MH
_____	Attend Counseling sessions with and/or without client
_____	Medical Records and/or Laboratory Reports (including Drug Screens)
_____	Collateral Interviewing for Client-Family Court Custody Evaluation
_____	Defendant Case History__, Police Reports__, Driving Abstract/JIS__
_____	Other_____ _____

I understand that my alcohol and/or drug treatment records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and all medical/mental health treatment is covered under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Parts 160 and 164, and cannot be disclosed with my written consent unless otherwise provided for in the regulations. DV records are also protected under State (RCW 71.05.390-WAC 275-56-240). I also understand that I MAY NOT revoke this consent at any time while under court supervision without court notification.

Purpose of Disclosure: ( )Continuity of Care ( ) Reporting to Court/PO ( ) Other_____

_____

Release Expiration Date and Reason:_____

* **If nothing is filled in this area, release expires within 30 days of patient signature**

Patient Signature:_____ Date:_____

_____ Date:_____

Signature of Parent, Guardian, or Authorized representative (if Client is under age 13)

Signature of FTR program Representative:_____