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)

Check each item applicable to request	Initial
( )Acknowledgement of Patient's Presence in Facility **ONLY**	_____
( )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	_____
( )Opioid Substitution Information	_____
( )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:_____