Charlotte Malkmus, MA, LMHC
621 Pacific Ave., Suite 100 Tacoma, WA 98402
253-355-2498

Authorization for Release of Health Information

Individual's Full Name ____________________________ Date of Birth _____________________

____
Street Address City State Zip Code

I understand and agree that:

• this authorization is voluntary;
• my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
• I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
• my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
• this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying Charlotte Malkmus in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received.

Who May Receive and Disclose my Information:

I authorize Charlotte Malkmus, LMHC to disclose my individually identifiable health information to the following person(s) or organization(s):

____
(Full Name of Person(s) or Organization(s))

____
(Full Address of Person(s) or Organization(s))

Type of Information to be Disclosed:
I authorize disclosure of all my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; **or**

I authorize only the disclosure of the following information:

____
(Type of Information)

Purpose of Disclosure:
My health information is being disclosed for the following purpose:

____
(Explain Purpose)

____________________________________ ________________
Signature of Individual Date