AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

This authorization for use or disclosure of medical information allows the Provider to release and or exchange protected information from your clinical record to/by the person or entity that you designate.

I hereby authorize Joseph Velazquez (MA, LMFTA), a representative from:

Anchored Vision: Family Therapy Services, PLLC.
1102 A ST. Suite 504.Tacoma WA 98402

To furnish:

____ Assessment
____ Dates of Treatment
____ Discharge Plans
____ Diagnosis
____ Entire File
____ Presenting Symptoms
____ Prognosis
____ Progress To Date
____ Psychiatric Evaluation
____ Psychological Testing Report
____ Treatment Plans & Recommendations
____ Other

To designee or representative of (Name): ____

(Address & Phone number): ____

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.I authorize the disclosure of the health information described above for the continuation and follow-through of appropriate treatment. The specific uses and limitation on the uses of my health information by Recipient are as follows:

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Client Health Information being used or disclosed under Federal Law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

Duration:
this authorization shall be effective immediately. I have carefully read and understand the forgoing. I consent to the release of the above-specified release of **Protected Health Information (PHI)**, which may include psychiatric illness and alcohol and/or drug abuse and dependence to those persons or agencies listed above. I further release my attending therapist, his associates from any liability arising from the release of this information or records to such designated persons or entities.

Restrictions: Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity. I understand that Provider cannot condition treatment upon me signing this authorization. Provider is authorized to disclose the protected health information specifically listed above until: ____________________ (authorization expiration date. If no date provided, this expiration will end one year after treatment or whatever shorter duration is mandated by law).

____ ____________

Signature of client or client's Authorized Representative *Date*

**If signed by other than client, please indicate the relationship between client and his/her Representative*.