ENVISION
INTEGRATIVE THERAPIES

Steffie Genevieve, MSW, LICSW, CDP, SAP
Therapist and Personal Coach
1005 N. Pines Rd., Ste. 40, Spokane, WA 99206
Phone: 509 850-5991 • Fax: 206-892-9709

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I understand that my records are protected under federal and state confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for by law.

Client Name: _____ **DOB**: _____

I authorize the release of confidential information about me to plan, and coordinate services, treatment, payment, and benefits for me or for other purposes authorized by law. I further grant permission for Steffie Genevieve and the listed provider/individual below to use my confidential information and disclose it to each other for these purposes.

☐ The provider/other named below requests information from Steffie Genevieve.
☐ Steffie Genevieve requests information from the provider/other named below.

Provider/Other: _____

Fax: _____ Phone: _____

I authorize release of information about my care in the following circumstances:

☐ Mental Health ☐ Substance Abuse ☐ Substance Abuse Evaluation

I authorize and consent to sharing the following records and information (check all that apply):

☐ Client records ☐ Health Care Information ☐ Treatment Plans ☐ Individual Assessments

☐ Records Listed: _____

☐ Payment records: _____

☐ Others (list): _____

I understand that unless revoked this authorization is valid for 90 days from date of signing or until _____.
I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

Information may be shared: ☐ verbally ☐ fax ☐ computer data transfer ☐ mail ☐ hand delivery

I understand that my healthcare information is protected by state laws RCW Chapter 70.02 and Federal Regulations Privacy Rule 45 CFR Part 160 and Subparts A and E of Part 164 that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, or unless otherwise provided by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my healthcare information, my information may be re-disclosed by that party and would no longer be protected. I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing.

Client Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Note: A photocopy or facsimile of the above signatures shall be considered in lieu of the original

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL ALCOHOL AND DRUG INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (11.2015)