Alliant Counseling and Consulting

110 Main Street Suite 104
Edmonds, WA 98020

200 1st Ave West Suite 400
Seattle, WA 98119

Name:_____ DOB: _____
Address: _____ City/State: _____
Zip Code: _____ Telephone Number: _____

PLEASE OBTAIN INFORMATION FROM:
Name of Provider/Organization: _____
Address: _____
City/State/Zip Code: _____
Phone Number: _____
Fax Number: _____

PLEASE PROVIDE INFORMATION TO:
Name of Provider/Organization:_____
Address:_____
City/State/Zip Code:_____
Phone Number:_____
Fax Number:_____

PURPOSE OF RELEASE:

- Further mental health evaluation, treatment or care
- Rehabilitation program development or services
- Treatment planning
- Other: _____

The records concern the time between _____ and _____

In the boxes below, the information to be disclosed is marked by an x; the items not to be released have a line drawn through them; page numbers are indicated when appropriate; and when written dates indicate when those records were mailed to the requester.

- Intake and discharge summaries ____
- Mental health evaluations ____
- Progress notes, and treatment or closing summary ___
- Medical history and evaluation(s) _____
- Developmental and/or social history ____
- Educational records ____
- Other ____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

- Do not release HIV-related information _____ Do not release drug and alcohol information _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that the action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer be protected by federal privacy regulations.

Signature of client: _____ Printed name: _____ Date: _____
Signature of parent/guardian/rep.: _____ Printed name: _____ Date: _____
I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.
Signature of witness: _____Printed name: _____ Date: _____

Copy for patient/parent/guardian_____Copy for source of records_____Copy for recipient of records_____