

Therapy for Individuals and Couples

David Sanders Counseling, LLC Redmond WA · (971) 220-5797 License #: MC60189034

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Client Name:		Client Date of Birth:		
This authorizes that the information	specified below	regar	ding the a	bove person be disclosed between:
David Sanders Counseling 15446 Bel-Red RD NE, Suite 430 Redmond WA 98052 (971) 220-5797 david@davidsanderscounseling.org		ND	Person or Street City Phone	State Zip
Specific Information to be Disclosed	:			
☐ Intake Evaluation ☐ Treatment Plan ☐ Progress Notes ☐ Psychiatric Evaluations ☐ Medical History ☐ Discharge Summary ☐ Psychological Evaluations ☐ Medical Diagnosis ☐ Other: ☐ Discharge Summary ☐ Haboratory Results ☐ Medications ☐ Other: ☐ Other: ☐ Inderstand that my records may contain information relating to mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel this authorization at any time, except to the extent that the action has already been taken. Unless canceled earlier by me, this authorization will expire in ninety (90) days from the signature date.				
Signature I am a Client Parent	□ Legal Guardiar	1		Date



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REVOCATION OF AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Client Name:	Client Date of Birth:				
I no longer want David Sanders to use and disclet treatment, billing and payment, and health care					
I understand that:					
 This request only applies after I sign the document. 					
 David Sanders may have already taken action based upon my earlier permission. 					
 David Sanders is allowed by law to use and disclose my health care information to complete treatment, billing and payment, and health care operations already in progress. I agreed to this when I signed the "Authorization for Release of Health Care Information." 					
 David Sanders is allowed or required by my permission under certain situations. 	Bavia sanacis is anowed of required by law to release health care information without				
David Sanders does not have to provide	any further health care services to me.				
Signature of Client or Legally Authorized Individual	Date				
Relationship to client if signed on behalf of the patie representative, etc.	ent by parent, legal guardian, personal				