Authorization for Disclosure of Healthcare Information

Jayme D. Fergoda, Ph.D, LICSW
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Phone: 360-685-4224
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Client Name:____________________ Birth date:__________ SS#______________

Previous Name(s):______________ Address:______________________________

Treating Provider: Jayme D. Fergoda, Ph.D, LICSW

Information is to be disclosed to ☐ Information to be obtained from ☐:

Name of Person/Agency: ____

Address: ______________________________ Phone:__________ Fax:__________

For purposes of: _____Treatment _____Forensic assistance _____ Evaluation_______Other:______________ __________

I authorize Jayme D. Fergoda, Ph.D. LICSW to release or obtain my:

_____ General Mental Health Record

_____ Information related to chemical dependency/substance abuse

_____ Psychotherapy Notes (the private content of your conversations with your therapist)

_____ Information related to HIV/AIDS and/or sexually transmitted diseases

_____ Other: ____

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this Authorization expires 12 months after the last dated signature.

______________________________ ______________________________
Signature of Client Date

Parent/Guardian signature is required for all children under age 13. For children age 13 and over, we encourage the parent/guardian to sign, but it is not required. *I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.*

______________________________ ______________________________
Signature of Parent/Guardian Date

______________________________ ______________________________
Signature of Witness Date

[12 Month Signature Updates]

______________________________ ______________________________
Signature of Client/Parent/Guardian or Authorized Representative Date

______________________________ ______________________________
Signature of Client/Parent/Guardian or Authorized Representative Date