



Kent Youth & Family Services  
 232 S. Second Ave. #201  
 Kent, WA 98032  
 253-859-0300; fax 253-859-0745

## Authorization For Use and Disclosure of Protected Health Information

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Hereby authorizes Kent Youth & Family Services to:

- Disclose information to:     Obtain\* information from:     Exchange\* information with:

\* I authorize the person or organization named below to disclose information to Kent Youth and Family Services.

Name: \_\_\_\_\_  
 Organization: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

### Information to be disclosed:

- Psychiatric information (if written records are disclosed, includes current prescribed medication, the most recent psychiatric evaluation and psychiatric medical notes for the past 6 months.)  
 Other mental health information (If written records are disclosed, includes the current treatment plan, and individual and group progress notes for the last 6 months.)  
 Insurance information \_\_\_\_\_  
 Other (specify): \_\_\_\_\_

For the purpose of (specify) \_\_\_\_\_

### Specific Authorizations

\_\_\_\_\_  
 (Initial)    **Drug & Alcohol:** I understand that my records may contain information, diagnosis or treatment for drug or alcohol abuse. I give my specific authorization for records to be released (CFR 42, Part 2).

\_\_\_\_\_  
 (Initial)    **STD/AIDS/HIV:** I understand that my records contain information regarding testing, diagnosis, or treatment of STD/HIV/AIDS. I give my specific authorization for these records to be released (RCW 70.24.105)

THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME, UNLESS THE AGENCY HAS ALREADY DISCLOSED THE INFORMATION. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE AT THE END OF TREATMENT.

\_\_\_\_\_  
 Signature of Client/ Legal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship or status if signed by anyone other than client (parent, legal guardian, personal representative, etc.)

### **REDISCLASURE PROHIBITED:**

This information has been disclosed to you from records whose confidentiality is protected by state or federal law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.