Samaritan
Center of Puget Sound
564 N.E. Ravenna Boulevard, Seattle, Washington 98115, (206) 527-2266

Consent for Exchange of Information

Client Name _____ Date of Birth_____

SSN _____ Previous Name _____

I authorize _____ and Samaritan Center of Puget Sound
Therapist

To disclose to ☐_____ and/or from ☐ _____ (Client must initial box/es if checked)

Name and Organization _____

Address _____ Telephone_____

Fax _____

City, State, Zip code _____

the following health care information:

_____ Health care information relating to the following treatment or condition:

_____

_____ Health care information for the date(s) below:

_____

_____ All health care information:

_____

_____ Other_____

This authorization ends: _____ in 90 days; or

_____ When the following occurs (but not longer than 90 days)

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request.

Once Samaritan center of Puget Sound gives out the information, the recipient might re-disclose it. I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

Date _____ _____
Signature of client

_____
Signature of parent or guardian if client is under 13

_____
Witness/Therapist

Please Note: You have the right to refuse to sign this form. We will not condition treatment on the completion of this authorization.