Authorization to Use and Disclose
Protected Health Information (PHI)

I, ____, hereby authorize the release of health care information
(Print client's name <u>and</u> date of birth)

TO / FROM (circle one or both):

Name and Organization: J Jason Chastain, LICSW, Chastain Counseling, LLC

Address: 9825 Sandifur Pkwy, Suite D, Pasco, WA 99301

Phone: 509-531-6698 Fax: 509-402-1176 Email: jjchastain@protonmail.com

TO / FROM (circle one or both):

Name and Organization: ____

Address: ____ City, State, Zip ____

Phone: ________________ Fax: ________________ Email: ____

By signing this Authorization, I authorize the use and disclosure of all health information, including the following:

☐ All Health Information about me, including my clinical records. This information may include, if applicable:

Yes	No	
☐	☐	Information about mental health diagnosis or treatment.
☐	☐	Information about diagnosis or treatment for alcohol or drug use, abuse/, or dependence.
☐	☐	Information about HIV/AIDS Testing or Treatment (including that an HIV test was ordered, performed or reported, regardless of whether the results were positive or negative).
☐	☐	Information about diagnosis or treatment of Sexually Transmitted Disease(s).

☐ Specific Health Information *including only*: ____

For the Purpose(s) of: ☐ Continuity of care ☐ Client request ☐ Disclosure for legal purposes

This authorization ends: (check one box) ☐ When Treatment Ends ☐ in one (1) year

I UNDERSTAND AND ACKNOWLEDGE THAT: My records may contain information related to my mental health; my written consent is required to release any health care information related to testing, diagnosis, and/ or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and or drug and/or alcohol use unless otherwise allowed or required by law; this authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent; I may refuse to sign this authorization or revoke authorization in writing at any time, except to the extent that the action has already been taken in reliance of it; information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by this provider, office, or HIPAA regulation; and commencement, continuation, or quality of treatment will not be conditioned on whether I sign this document except insofar as PHI is necessary to assessment, report, or treatment contemplated by this authorization. However, failure to sign here may result in a denial of insurance benefits by your insurer. PHI may be conveyed in writing, fax, or verbal/telephone communication. I have received a copy of my signed authorization.

I hereby release the provider and recipient of my PHI from any and all legal liability that may arise from the use and disclosure of information as set forth in this Authorization.

____ ____________________
Signature of client or legally authorized representative Date

____
Relationship if signed on behalf of the client by parent, legal guardian, personal representative, etc.