Brian DesRoches, MSC, Ph.D., LMFT, License # 1459
2910 E. Madison Street Suite 201 Seattle, WA 112
Phone 206-323-6114 Fax 206-721-5116

Authorization for Use and Disclosure of Protected Health Care Information

I, _____ _____ Print Full Legal Name

give my permission to Brian DesRoches, Ph.D., LMFT to release, obtain and exchange information regarding protected health care information with:

_____ Recipient's name and title

Type of Information to be released:

____ Treatment Goals and/or Progress ____Clinical Recommendations
____ Assessment Results and Recommendations ____ All information
____ Specific Information not described above _____

Purpose of Disclosure of Protected Health Care Information :

_____Coordination of/continuity of care _____ Transfer of Care ____Other_____

I understand that my records are protected under the Federal and/or State Confidentiality Regulations and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CRF, Parts 160 and 164, and cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. I understand that my written consent is required to release any information relating to the following: psychiatric and mental g\health disorders; drug and/or alcohol use; diagnosis; treatment for HIV/AIDS and STD's and hereby grant my consent and authorize release of this information as provided for in this Authorization form.

This authorization expires 90 days from the date of signing.

Authorized Signature _____Date of signing _____

Witness Signature if required _____