Marlene Travis, PLLC

Marlene Travis, MS, MEd, LMHC, NCC

Authorization to Release Protected Health Information (PHI)

I, _____ hereby authorize Marlene Travis, MS, MEd, LMHC, NCC to:
(Client Name)

❑ **SEND**	Information to:
❑ **OBTAIN**	Information from:
❑ **EXCHANGE**	Information with:

_____
Name Organization

_____
Address

_____

_____
Phone Number Fax Number

PHI may be transmitted by telephone, fax, mail, or in person unless I specify here: ONLY _____

PLEASE CHECK and INITIAL SPECIFIC CONSENTS	
I authorize the release of the following: ❑ Attendance in therapy ❑ My diagnoses or initial assessment ❑ Case / Treatment plan and notes ❑ Physician notes / medical records ❑ Psychiatric evaluation ❑ When treatment terminated and why ❑ Information relevant to coordinating care ❑ Other _____	**My initials indicate my authorization to release the specified information:** _____ Mental health (diagnosis, treatment plan, symptoms, medications) _____ HIV/AIDS or public health disease _____ Sexually transmitted infections _____ Drug and/or alcohol use I am aware my records may contain health care information relating to testing, diagnosis, or treatment for HIV/AID, other STIs, chemical dependence, and/or mental health.

I understand **my records are protected** under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand this PHI in my records may be essential to the continuity of care and will be kept confidential and **used for professional purposes only.** I understand that re-disclosure of my health information by the Recipient, if unauthorized, is a potential risk. If re-disclosed, privacy laws may no longer protect the information. I understand that **I do not have to sign this** authorization in order to obtain treatment benefits from Marlene Travis, except for health care services necessary to create any assessment or report contemplated by this authorization.

I understand that **I may revoke this** authorization in writing at any time with a form available to me from Marlene Travis; that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on this authorization, including provision of health care services requiring subsequent disclosure to effect payment. I understand I am entitled to a copy of any authorization I sign. Copies of this document may be considered the same as the original.

By my signature, I hereby release the above parties from any legal liability resulting from the release of this information. The effective date of this authorization will be the date of my signature below. If not previously revoked, this authorization will expire:

- in ninety (90) days or ninety (90) days following termination of treatment and when account is paid in full
- or upon the following date _____, or event _____.

_____ _____
Signature of Patient (or Parent or Legal Guardian) **Date**

Marlene Travis, PLLC ♦ Mailing Address: PO Box 403 ♦ Ellensburg, WA 98926 ♦ 509.852.7070 (calls only; no text)