Palouse River Counseling
340 N.E. Maple St, Pullman, WA 99163
Phone: (509) 334-1133 FAX: 509-332-1608

RELEASE OF INFORMATION

I, _____ DOB: _____
do hereby authorize *Palouse River Counseling*, a licensed treatment provider to:
(Place your initials on all that apply):
_____ **Release to** and/or _____ **Receive from** the following person or institution, information obtained in confidence from me;

or I do hereby authorize *Palouse River Counseling* to _____**Release to** and/or _____**Receive from** records pertaining to my child or who is legally in my care as a court appointed guardian (who is 12 years of age or younger):
Child's name**:** _____ DOB: _____

Disclose this information to whom: _____/_____
(Name of Agency) **(Relationship)**
Address: _____ **Phone:** _____
_____ **Fax:** _____

(Place your initials on all that apply):
MENTAL HEALTH RECORDS: This release is limited to the following information
___ Any and all information in record including, but not limited to history, diagnosis, progress in and/or response to treatment and prognosis.
___ Psychological evaluation, including testing and results, treatment, discharge summaries and reviews.
___ Psychiatric evaluation.
___ Medication utilized and related information.
___ Full disclosure of information relating to my HIV/AIDS/STD status.
CHEMICAL DEPENDENCY RECORDS: This release is limited to the following information
___ Drug and alcohol records and related information including:
___ Evaluation Results; ___ Treatment Recommendations; ___ Discharge Summary; ___ Progress Notes;
___ Group Notes; ___ Other (specify)_____

___ Other (specify): _____/ _____
Consumer Initials

The information requested/released is for the purpose of:
___ Evaluation ___ Treatment planning ___Coordination of services ___Other _____

I authorize the receipt or release of psychiatric records, mental health records, drug and alcohol records and HIV/STD related information as applicable. I understand that my records are protected under the Federal/State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that my consent is subject to a written revocation by me at any time except to the extent that action has been taken in reliance on it (e.g. court related, probation, parole, etc.) (**Consumer initials** _____).

This release of information is valid for 90 days past the date of discharge from Palouse River Counseling or unless otherwise specified below (please specify the date, event, or condition upon which this consent expires): _____

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent 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 above unless further release is authorized by law.

I acknowledge that the information to be released was fully explained to me, and this consent is given voluntarily by me of my own free will.

_____ _____ _____ _____
Consumer (If under 13, parent) **Date** PRC Representative Date