Tanya Larson, M.A., LMHC
Heartfelt Transformations

1102 A Street, Suite 202C
Tacoma, WA 98402
(253) 686-9421

CONSENT FOR RELEASE OF INFORMATION, REPORTS, AND/OR RECORDS

To: ____

Title: ____

Address: ____

____

Home: ________________ Cell: _____________ Work: _______________ Fax: ________________

Concerning my client: ____

Date of Birth: _____/_____/_____ Phone: __________________________

Address: ____

____

I (the client) hereby grant permission to Tanya Larson to release the following protected health information from my client record to the above listed party:

Exchange of information in

- — Verbal
- — Written
- — Form of Intake
- — Closing Information
- — Evaluations
- — Case Notes
- — Specific Information Only, from the file ____________________________
- — Complete record excluding billing information
- — Complete record including billing information
- — Encompassing the following dates: From intake to closing or present date
- — These dates only ________ to _______

FOR THE PURPOSE OF:

NO SECOND PARTY INFORMATION MAY BE RELEASED. THE RELEASE IS EFFECTIVE FOR 90 DAYS FROM DATE OF SIGNATURE, OR UPON THE OCCURRENCE OF (date, event, circumstance) ____________________________, OR OTHERWISE IF CLIENT SPECIFIES A TIME LESS THAN 90 DAYS_____________________. Client information is protected under Federal (42 CFR) and State (RCW 71.05.390) and HIPPA confidentiality regulations. I acknowledge that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. Photocopies or FAX copies are equivalent to the original.

____	___________________________	__________
Client signature (or client's authorized representative)	Relationship or status if signed by anyone other than client	Date signed

____

Printed name of authorized representative

If client had (at the time of counseling services) or has currently reached 13th birthday only he or she may authorize disclosure related to mental health treatment.