Allan G. Fitz, PhD
Psychologist

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Phone: 360-746-2995 Fax: 360-746-3458

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Client Name: _____ **Birth Date:** _____

Address: _____

I authorize the written and verbal exchange of any confidential, protected, or privileged health care information between **Dr. Allan Fitz** and the individuals listed below. I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric diagnoses/treatment, or psychological/neuropsychological test results.

INITIAL BELOW ANY INFORMATION NOT TO BE RELEASED FROM THE RECORDS.

_____Psychological / Psychiatric Records
_____Chemical dependency/substance abuse or treatment
_____Psychological/Neuropsychological testing
_____Other: _____
_____Psychological evaluation and treatment
_____HIV/AIDS and/or sexually transmitted diseases

Note: *We have a dedicated fax line for privacy purposes. However, it is possible a provider could dial a wrong number in attempting to fax the requested documents. In such an event, most fax cover sheets indicate that the information contained therein is confidential and, if the document was received in error, the documents should be destroyed and the sender notified.*

TO/WITH:

_____ Name: _____
Address: _____
_____
_____
Phone: _____ Fax:_____

TO/WITH:

_____ Name: _____
Address: _____
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Phone: _____Fax: _____

TO/WITH:

_____ Name: _____
Address: _____
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Phone: _____ Fax:_____

TO/WITH:

_____ Name: _____
Address: _____
_____
_____
Phone: _____Fax: _____

I understand that this release expires three years from the signed date, or that I may revoke this Authorization in writing at any time except to the extent that action has been taken.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

Parent/Guardian signature is required for all children under age 13. For children age 13 and over, we encourage the parent/guardian to sign, but it is not required. *I understand that information being requested for the above minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.*