charissawalson pllc 7808 Pacific Ave.- Suite 8- Tacoma WA 98408 ph: 206-747-9604

Authorization for Release of Records and Mental Health Information

Records requests may take up to up to 15 days. There is a fee for records this will be determined and disclosed before date of pick up. If the client is a minor but is authorized to consent to health care without parental consent (13 years), under federal law the client must sign this release form.

Name:_____Date of Birth:_____Age:_____

Address:_____State:_____Zip:_____

Phone:_____

If there is a Parenting Plan in place that charissawalson,pllc will need a copy. Is there a Parenting Plan? Y or N

I authorize charissawalson,pllc to release/obtain information or records to/from the following Person(s):

Name: _____

Address:_____

Phone:_____Fax:_____

Relationship to Client:_____

Type of Disclosure: **Exchange of Information:** **Verbal Only** **Other:_____**

Copies of Records **Letter** **Other (i.e., Summary Report)_____**

Please specify the information you authorize to be released:

Intake packet Clinicial **Measures and Assessments** **Billing Summary**

Closing/Transfer Summary Treatment Notes All / or Dates:_____

All charissawalson, pllc Generated Correspondecne (Faxes, Letters, Emails)

Other (be specific):_____

*CANNOT BE RELEASED: Non-charissawalson,pllc Generated Documents (i.e. physician reports, medical info, parenting plan, court orders, school documents, etc.)

The Purpose of this Release is: _____

Expiration of Authorization:

Unless otherwise, revoked this Authorization expires on_____

If no date is indicated, the Authorization will expire 90 days after the date of my signing this form.

I understand that this authorization is voluntary. I understand that my records are protected under the Federal(42CFR) and the State(RCW 71.05.390) confidentiality regulations. I also understand that I may revoke this authorization at any time by notifying the providing organization in writing, except to the extent that action has been taken in reliance of it.

Printed Name of Client/Guardian_____

_____ _____ _____ _____

Name of Client/Guardian Date Signature of Staff Date

I request that the authorization be revoked immediately (effective on the following date):_____