Mark Dooley Psychotherapy
MA, MES, LMHC, CMHS
1116 Key Street, Suite 105 Bellingham, WA 98225 (360) 303 0695

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name: ____ Date of Birth: ____________

I hereby request that there be a mutual exchange of my records and information between:
Mark Dooley of Associates in Mental Health and ____
of ____

This request and authorization applies to the following information from my records, to specifically include:

( ) verbal ( ) written

( ) Health care information relating to the following treatment or circumstances: ____________________
( ) All health care information to coordinate a treatment plan, assist in diagnosis, and assure continuity of care.
( ) School related information, academic performance, social adjustment, test results, IEPs, special education reports.
( ) Other: ____

Mark Dooley may use or disclose health care information regarding testing, diagnosis, and treatment for:

( ) sexually transmitted diseases
( ) psychiatric disorders/mental health
( ) HIV/AIDS
( ) drug and/or alcohol use

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health care information for a third party or to o allow another practitioner to receive or give the above noted information to my provider.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Mark Dooley or Associates In Mental Health based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are to fill out a revocation form (a form is available from your provider) or write a letter to your provider.

Once health care information is disclosed, the person or organization that receives it may redisclose it. Privacy laws may no longer protect it.

I agree to hold harmless Mark Dooley from any claims which arise from the release of any information which has been agreed to on this form. This release is valid for the time period indicated below and can be revoked in writing at any time, except to the extent that action has been taken in reliance on it. I understand that 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 that once information and/or records leave Mark Dooley's practice or Associates in Mental Health that he is unable to provide further protection of them. I further acknowledge that the use of this information was explained to me and is given voluntarily by me and of my own free will.

Release is given for:

( ) 30 days following signature ( ) 60 days following signature ( ) 90 days following signature ( ) other: ____________
____

____ ____________
Client or Client's Authorized Representative Date

****Mental health professionals are mandated to report suspected abuse. Confidentiality may also be breached in cases of imminent risk of harm to self or others.***