Carrie Sheppard, M.Ed.

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____

Hereby authorize release of health information of:

☐ yes ☐ no myself
☐ yes ☐ no my child (name) _____

I hereby authorize disclosure of the following specific information:

☐ yes ☐ no Summary of social/family history
☐ yes ☐ no Summary of treatment provided
☐ yes ☐ no Written records
☐ yes ☐ no Other: _____

For the purpose of:

☐ yes ☐ no Treatment planning
☐ yes ☐ no Case coordination
☐ yes ☐ no Third party billing
☐ yes ☐ no Other: _____

☐ To Carrie Sheppard: 27023 164th Ave SE, Covington, WA 98042
☐ From Carrie Sheppard: 27023 164th Ave SE, Covington, WA 98042
☐ Mutual Exchange:

☐ To Name: _____
☐ From: Organization: _____
☐ Mutual Exchange Address: _____
Phone/Fax: _____

I understand that health information cannot be released without my specific consent. I understand that this consent can be revoked at any time.

Client Signature: _____ Date: _____/_____/_____

Parent Signature: _____ Date: _____/_____/_____
(if client is a minor)

Witness Signature: _____ Date: _____/_____/_____
Carrie Sheppard M.Ed., LMHC

This authorization applies to any health information gathered within 90 days from the date of this signature.