Cedars Psychology Services
Promoting Hardiness in Children, Teens & Young Adults

Authorization to Use and Disclose Protected Health Information
625 S. Diamond Street, Centralia, WA 98531
Phone (360) 836-0493 ◆ Fax (360) 339-7808

Client Name: _____ DOB: _____/_____/_____

With my signature below, I authorize Rosemarie Downey-McCarthy, Ph.D. at Cedars Psychology Services to:

◻OBTAIN information from   ◻DISCLOSE information to

Contact Person: _____ Organization: _____

Address: _____ Telephone: _____

City, State, Zip: _____ Fax: _____

Information to be used/disclosed consists of mental healthcare information, including:
◻Assessment or Evaluation   ◻Treatment Plan   ◻Notes   ◻Coordination of care information
◻Other: _____

The purpose for the disclosure/communication:
◻ Coordination of care   ◻Other:_____

I understand that additional laws about mental health and alcohol/drug treatment information may apply.
I understand and agree that this information will be disclosed if I place my initials in the applicable space.

Initial: _____ Mental health information
Initial: _____ Drug/alcohol diagnosis, treatment, or referral information

Other information
I understand that I am not required to sign this authorization. If I refuse to sign this, it will not prevent me from getting mental health treatment at Cedars. The only exception is if the services I am seeking are only for providing health information to someone else and this authorization is needed to make the disclosure.

I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reasons described here. If Cedars has already used or disclosed information, that cannot be undone. To revoke this authorization, I can request the form from Rosemarie Downey-McCarthy and return the completed form to her.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of mental health information and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization expires 60 days after the completion of treatment or: _____

Signature
I have read this authorization and understand it.

Client signature: _____ Date:_____

Parent/Guardian/Representative signature: _____Date:_____

If personal rep, print name:_____
Relationship to client: ◻Parent   ◻Legal guardian   ◻Power of Attorney/Healthcare   ◻Other_____