Sound Psychology

3515 SW Alaska Street • Seattle, WA 98126
Phone: 206-937-1481 • Fax: 206-937-6236

CONSENT FOR DISCLOSURE
Patient Health Records and Other Information

I, _____, D.O.B. __/__/__ S.S. #: _____,

authorize:

_____
(Name of Person)

_____
(Address)

_____ _____ _____ _____
(City) (State) (Zip) (Phone Number)

to share information specified below to facilitate patient care of above individual. I understand that my records may contain information regarding the diagnosis or treatment for alcohol, drug, psychiatric/mental health, STD, or HIV. I give my specific authorization for these records to be released to:

David R. Knopes, Ph.D. / Sound Psychology
3515 SW Alaska Street
Seattle, WA 98126
(206) 937-1481 Phone (206) 937-6236 Fax

INFORMATION TO BE RELEASED	Yes	No
Duration of program involvement and attendance	___	___
Summary of treatment participation/progress reports	___	___
Evaluations of treatment participation	___	___
Medical history/social history	___	___
Alcohol and other drug history	___	___
Legal history	___	___
Psychological/psychiatric testing, evaluation and reports	___	___
Other (specify) _____	___	___

I understand that my records are protected under the Federal (42CFR) and State (RCW 71.05.390) confidentially Law and regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically as specified below or in ninety (90) days without such specification. This information released may be obtained via mail, telephone, fax, or in person.

Specification of the date, event, or condition upon which this consent expires: _____

_____ _____
Patient/Guardian Significant **Date**

_____
Witness