JOY RUFENER
ART PSYCHOTHERAPIST

AUTHORIZATION TO RELEASE INFORMATION

Client Name	Client Birth Date and Social Security Number

This is to authorize that the information specified may be disclosed between:

Joy Rufener, MA, LMHCA 324 15th Ave. E, Suite 201 Seattle, WA 98112	Person or Facility: _____
and	_____ Street _____ City State Zip
Phone: 206.890.6123	Phone: _____
Attention: _____	Attention: _____

Specific Information to be disclosed:

☐ Treatment Dates, Diagnosis, Modality & Frequency of Treatment ☐ Functional Status
☐ Symptoms in Treatment ☐ Intake/Discharge Summary ☐ Medical Records
☐ Mental Health Evaluations ☐ Treatment Summary ☐ Developmental/Social History
☐ Redacted Client Record ☐ Other:

Purpose of Disclosure: ☐ Legal, ☐ Referral, ☐ Care Coordination, ☐ Discharge Planning, ☐ Other:

I understand that my records may contain information relating to mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel this authorization at any time, except to the extent that the action has already been taken. Unless canceled earlier by me, this authorization will expire in ninety (90) days from the signature date.

Signature: _____ Date: _____
Client _____ Parent _____ Legal Guardian _____