WILLIAM H. SINGER, Ph.D.

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

I DOB:

Authorize Dr. William Singer to disclose *I* exchange specified confidential medical, psychiatric (including alcohol and/or drug), HIV / AIDS test results or diagnosis, and *I* or educational information during my treatment s and from.

(Name and address of person *I* organization to whom disclosure is made)­­­­­­­­­­­­­­­­­

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Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the purpose of an exchange of information by: **PHONE / FAX / LETTER /EMAIL**

**Consent applies to all of the following:**

* Dates of Attendance or other treatment programs (CD, DV, or MH)
* Reports on Patient’s progress towards treatment objectives & attendance
* Program Discharge Summary from CD, DV, or MH
* Psychological Test Reports
* Medical Records
* Medical or Laboratory Reports
* Chemical Dependency and/or Domestic Violence Records
* Other:

**Limited:**

**[\_] LIMITED to the following: or check below:**

**Custody Evaluation Collateral consent for information Chart Notes**

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR, Part 2 or Health insurance Portability and Accountability Act (HIPAA) and State (RCW 71.05.390 - WAC 275-56-240). Clinicians may discuss care about mutual patients without written consent unless specifically prohibited by me. Additionally, my alcohol and/or drug treatment records are also protected under the federal regulations 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This release for court related services will expire ninety (90) days after completion of court proceedings or after discharge from treatment whichever is latest. This release will remain in place unless written notification of termination is received.

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. I understand that Dr. Singer will not condition treatment, payment, or eligibility for benefits on whether this authorization is signed.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent if minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_