

Consent for Release of Protected Health Information

I authorize Jordan Klekamp at Atlas Counseling PLLC to disclose Information to and/or obtain Information from the person or persons named below:

Name _____ Organization _____
How they know me _____ Phone # _____
Fax # _____ Email _____
Mailing address _____

Jordan Klekamp at Atlas Counseling PLLC may communicate with the above named person(s) in the following ways:

- in person telephone email fax physical mail

Information Jordan Klekamp May Share About Me:

- Participation in counseling
- Billing
- Scheduling
- Attendance
- Diagnosis
- Counseling goals
- Progress summary
- Initial assessment/reviews
- Session notes
- Closing summary
- Other _____

Information the Person(s) Above May Share About Me:

- School attendance
- School performance
- School records
- Physical health summary
- Physical health records
- Hospitalization summary
- Medication history
- Mental health information
- Treatment summary
- Psychological evaluation/test results
- Other _____

The purpose of this release of information is _____.

This consent will automatically expire (1) one year after the date of my signature or (2) one month after I end counseling. I understand I have the right to refuse to sign this form and that I may revoke my consent at any time (except to the extent that the information has already been released).

I understand that my records may contain information about the diagnosis or treatment of substance use. I give my specific consent for this information to be shared (CFR 42, Part 2).

Client/Legal Representative Signature

Date

I understand that my records may contain information about the testing, diagnosis, or treatment of STD/HIV/AIDS. I give my specific consent for this information to be shared (RCW 70.24.105).

Client/Legal Representative Signature

Date

I hereby confirm that I have reviewed this consent form and agree to authorization this release of information as of the date of my signature below.

Client/Legal Representative Name

Client/Legal Representative Signature

Date

Authorization Extension

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional 12 months as of the date of my signature below.

Client/Legal Representative Name

Client/Legal Representative Signature

Date