Promoting Balance and Stability in Kids and Teens

GYRO PSYCHOLOGY SERVICES, INC

## Request/Authorization to Release Confidential Information

Instructions: Please complete one request/authorization per individual party/agency.

I, _____ _____ _____
PATIENT'S NAME Date of Birth Today's Date

Hereby authorize Gyro Psychology Services, Inc. to obtain information and/or disclose information to:

My child's: Doctor School Other: Please specify:_____

Name of person(s)/agency: _____

**INFORMATION AUTHORIZED AND REQUESTED:**
Unless otherwise specified below, this authorization and request includes:

- all diagnosis and diagnostic assessments,
- all treatment summaries and impressions,
- the number and dates of sessions,
- all mental health, medical and other health care information,
- all cognitive, achievement or other psycho-educational test results, all IEPs and all other educational and behavior information from school,
- all legal information,
- all information obtained from third parties, and
- any other information which may be useful for evaluation and treatment.
- If you would like additional information to be released, please specify: _____

_____

**DURATION**: The authorization will remain in effect for ONE YEAR from this date unless otherwise specified below.

**LIMITS**: Please specify any limits: *(If no limits are specified, this request/authorization has no limits on the information requested/ authorized for disclosure).* _____

I understand that my records are protected under Washington State Regulations, Chapter 275-56-240 WAC and Chapter 71.05 RCW, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This authorization addresses and permits the release of any and all medical information protected by the Drug Abuse Office and the Treatment Act of 1972 (P.L. 92.255), the Comprehensive Alcohol Abuse and Alcohol Prevention Treatment Rehabilitation Act amendments of 1974 (P.L. 93.282), and Federal Regulations (CFR 42) which covers Drug and/or Alcohol Information release. I also understand that my written consent is required to release any information related to testing, diagnosis, and/or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and alcohol use, you are specifically authorized to release all health care information related to such diagnosis, testing or treatment. This consent shall expire in one year unless updated or revoked prior to that date, in writing. Photocopies and facsimiles of this authorization and signature are considered as valid as the original.

_____ _____
Signature of Parent/Guardian (***required***) Printed Name Date

_____ _____
Signature of Patient *(*required if 13 years or older*) Printed Name Date