Malone Therapy PLLC
Mallory Malone, MA, LMHC, LMFT
13303 NE 175th St., Suite A
Woodinville, WA 98072
P: 425.329.6177

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Client name: _____ Previous name: _____ Date of birth: _____

Address: _____

Phone number: _____ Email: _____

I, _____, hereby request and authorize the release of health care information TO / FROM (circle one or both):

Name and Organization: _____

Address: _____

City, State: _____Zip Code: _____Phone: _____

TO / FROM (circle one or both):

Name and Organization: _____

Address: _____

City, State: _____Zip Code: _____Phone: _____

By signing this Authorization, I authorize the use and disclosure of all health information, including the following:

☐ All Health Information about me, including my clinical records. This information may include, if applicable:

Yes	No	
☐	☐	Information about mental health diagnosis or treatment.
☐	☐	Information about diagnosis or treatment for alcohol or drug use, abuse, or dependence.
☐	☐	Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).
☐	☐	Information about diagnosis or treatment of Sexually Transmitted Disease(s) or Infections.

☐ Specific Health Information *including only*:

_____

For the Purpose(s) of: ☐ Continuity of care ☐ Client request ☐ Disclosure for legal purposes
☐ Other _____

This authorization ends: (check one box) ☐ in one (1) year ☐ when the following occurs: _____

I UNDERSTAND AND ACKNOWLEDLGE THAT: My records may contain information related to my mental health; my written consent is required to release any health care information related to testing, diagnosis, and/ or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and or drug and/or alcohol use unless otherwise allowed or required by law; this authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent; I may refuse to sign this authorization or revoke authorization in writing at any time, except to the extent that the action has already been taken in reliance of it; information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by this provider, office, or HIPAA regulation; and commencement, continuation, or quality of treatment will not be conditioned on whether I sign this document except insofar as PHI is necessary to assessment, report, or treatment contemplated by this authorization. However, failure to sign here may result in a denial of insurance benefits by your insurer. PHI may be conveyed in writing, fax, or verbal/telephone communication. I have received a copy of my signed authorization. **I hereby release the provider and recipient of my PHI from any and all legal liability that may arise from the use and disclosure of information as set forth in this Authorization.**

_____

Signature of client(s) or legally authorized representative Date Time

_____

Relationship if signed on behalf of the client by parent, legal guardian, personal representative, etc.