



Authorization to Release Protected Health Information

I, _____ authorize Hannah Fischer, LPC, LMHC
(503) 680-2478, (360) 635-1851 to mutually share with:

(name, phone) _____

(address) _____

Any and all information about _____,

For the purposes of _____,

I understand that the protected health information may be verbal or written.

I understand that I waive my rights of confidentiality to those above and their supervisors.

I understand that this communication may include drug, alcohol, mental health, medical, legal, financial, insurance, or HIV-related information.

I understand that Hannah Fischer, LPC, LMHC cannot control unauthorized redisclosure by recipient.

This authorization does not include disclosure for future health care services received more than 90 days from the date of last signature.

This release may be revoked in writing at any time, except when the disclosure has been made in good faith reliance on this release.

I understand that I have the right to refuse to sign this authorization and my refusal will not condition treatment, payment, enrollment, or eligibility for benefits.

Date of Signature: _____

Signature of Client _____ Client Date of Birth: ___/___/___

Signature: Parent/Guardian _____ Parent Date of Birth ___/___/___

