

# Authorization to Release Information



DAVID J KOSINS PHD  
Licensed Psychologist

Client Name	Client Date of Birth	Date authorization is initiated
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This is to authorize that the information below regarding the above person be disclosed between:

<b>David J. Kosins, Ph.D.</b>	_____	
318 W. Galer St., Suite 201	Person or Facility	
Seattle, WA 98119	<b>and</b>	_____
Phone: (206) 285-0900	City	Street
	State	Zip
	Phone	_____

This authorization shall remain in effect until: \_\_\_\_\_ (Fill in an expiration date or an event that relates to the purpose of the disclosure.) \_\_\_\_\_ Termination of Services \_\_\_\_\_ Other (please specify) \_\_\_\_\_

*If this authorization does not contain an expiration date or event, it expires 90 days from the date of my signature.*

Specific information to be disclosed:

<input type="checkbox"/> Intake Evaluation	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Laboratory Results
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychological Evaluations	<input type="checkbox"/> Progress Note
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medical History	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Medications	<input type="checkbox"/> Medical Diagnosis	<input type="checkbox"/> Other: _____

I understand that my records may contain information relating to my mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel authorization at any time, except to the extent that the action has already been taken. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Note: A photocopy or facsimile of this authorization shall be considered in lieu of the original.