Erik Bohlin, M.A. LMHC
9623 32nd ST SE, Suite A-110
Lake Stevens, WA 98258
425-334-8916 Fax: 425-368-3738

AUTHORIZATION FOR USE OR DISCLOSUREOF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY PATIENT / REPRESENTATIVE

Type of Information to be Disclosed:

I, ____ hereby authorize **Erik Bohlin, M.A.** to use and/or disclose
(name of Client or Guardian)

the following protected health information for _________________________________ Date of Birth _________:
Print name of Patient

- ❑ Records - outside health provider
- ❑ Treatment Summary
- ❑ Telephone Consult of current issues
- ❑ _______________________________________

To: Recipient of Protected Health Information:

____
Physician, Counselor, or other Party   Name of Healthcare Facility

____
Address   City   State   Zip   Phone   Fax No.

Deliver By
❑ Mail ❑ Fax ( ) _____________ ❑ Phone ( ) __________________ ❑ E-Mail ________________

Revocation / Redisclosure:
It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred based on prior authorization, and/or including provision of health care services requiring disclosure to effectuate payment. Unauthorized redisclosure by recipient is a potential risk.

Duration:
If not previously revoked, this authorization will expire: ____
(must specify date, event, or condition)

Specific Limitation: Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

Signature:
This Authorization covers protected health information pertaining to _____________________________________.
Print Name of Patient and Date of Birth

Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of that signature (initial or renewal). I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits.

____
Signature (Patient/Parent/Guardian/Other legal representative for health care decisions)   Date

____
Witness   Date

____
Renewal Signature (if previous expired or cancelled and want to renew)   Date