Julie A. Church, R.D, C.D.
1107 NE 45th Street, Suite 410, Seattle, Washington 98105
Phone: 206-854-8959 JulieChurchRD@yahoo.com

Consent for Release of Information

Patient Name:_____ Date Of Birth___/___/____

Phone: _____

Address: _____
Street/PO Box City State Zip

I, the undersigned patient or legal guardian, hereby understand that Julie Church does regular professional consultation with colleagues where conversation about my case could occur. I also authorize: ___ verbal, ____ written information to be __released by, ___received by, or ___exchanged between: Julie A. Church, R.D, C.D.
1107 NE 45th Street, Suite 410, Seattle, 98105

And the following:

Family/Significant Other Name_____Phone_____
_____ Address_____
Patient Initial Here

Facility/Agency Name_____Phone_____
_____ Address_____
Patient Initial Here

Therapist Name_____Phone_____
_____ Address_____
Patient Initial Here

Medical Provider Name_____Phone_____
_____ Address_____
Patient Initial Here

Other_____ Name_____Phone_____
_____ Address_____
Patient Initial Here

Other_____ Name_____Phone_____
_____ Address_____
Patient Initial Here

PURPOSE: Diagnostic/treatment planning; facilitating/coordinating continuing treatment; discharge/aftercare planning and support; or for the following purpose:_____

INFORMATION TO BE RELEASED:
___ Initial Evaluation ___Discharge Summary ___Medication Information
___ Lab Reports ___Progress Notes ___Appointment Attendance
___ Other (specify) _____

EXPIRATION DATE: ___One year from the signature date
SPECIFIC AUTHORIZATION:

I understand, upon my request, I may receive a copy of this release and that the information released may be mental health or substance abuse related. I also understand there may be a charge, payable in advance, for the copying and conveyance of records released. I further understand the above consents can be withdrawn by me, in writing, at any time. I cannot, however, hold exception to actions that have taken place before I withdrew my consent.

Information which is being disclosed is from records whose confidentiality is protected by state or federal law. 42 CFR-Part2 prohibits disclosure or re-disclosure, without the written consent of the person to whom it pertains, or as otherwise permitted by state law.

_____ _____ _____
Patient Signature Date Parent or Legal Guardian Signature

_____ _____ _____
Witness Signature Date Relationship to Patient