Release of Information to Necessary Parties

FULL FLIGHT WELLNESS

I, _____(DOB)_____, hereby authorize:

_____Person or facility

_____Address

_____ Phone _____Fax

To release information/records to and receive information from:

T. Aisha Edwards, LPC LMHC
280 E Evergreen Blvd #A
Vancouver WA 98661
503 893 5931 o
503 296 2577 f

For the following purpose(s):

____ Mental health evaluation, treatment, or care ____ Treatment planning ____ Care Coordination ____ Crisis Support/Intervention
____ Intake and discharge summaries ____ Medical history and evaluation(s) ____ Developmental and/or social history
____ Progress notes _____ Other:

Select only one:

_____ Please forward the records via Fax/Phone/Verbal _____ Please forward the records to the address written above.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: _____ Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent
that action based on this consent has already been taken. This consent will expire automatically after 365 days from the date on which it is signed, or upon fulfillment of the purposes stated above. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer protected by federal privacy regulations.

Print _____ **Signature** _____ **Date** _____