Cypress Counseling Center
Michelle Langstraat MA, LMHCA
6320 Evergreen Way, Suite 206
Everett, WA 98203

Authorization to Release/Obtain of Information

Client Name _____

Address _____

Date of Birth _____

To: _____ Address: _____

_____

Type of Release: ____ Mail to Provider above or ____ Fax to provider (if applicable)
____ Phone Consultation

Timeframe: I would like records sent for the following dates _____

What to release for Special Protection Records
____ Consultations ____ Progress Notes ____ Physician Information
____ Medical (History and Physicals) ____ Discharge Summaries
____ Evaluations

Release for Special Protected Records
____ Diagnostic Records/Treatment Re: Aids or other infectious diseases
____ Diagnostic Records/Treatment of Drug and Alcohol Abuse
____ Treatment and or Consultations for Mental Health or Psychiatric Care

Purpose of Release
____ Continuity of Care ____ Follow up Related to an Injury ____ Legal Purposes
____ Personal Use ____ Other _____

Expiration Date: This authorization will expire in 60(sixty days) or if revoked by the client in writing to the above name provider. If this release is for our Physician, it will be good for 6 months. I understand that this Authorization can be revoked at anytime.
Once these records are received they will not be released to any other entity without authorization by the named client.
I have read and I understand this information. I have received a copy of this form and I am the client or authorized to act on behalf of the client to sign this document verifying authorization for the use of disclosure of the protected health information und the above stated terms.

_____ _____

Date Signature of Client/Signature of Legal Representative Relationship