ABCD, INC. | ASSOCIATES IN BEHAVIOR & CHILD DEVELOPMENT

NORTHGATE EXECUTIVE ONE
155 NE 100TH STREET • SUITE 306 • SEATTLE WA • 98125-8014
Main: 206-569-3361 • Fax: 206-361-1598

CLINICAL PSYCHOLOGY
S. Wayne Duncan, Ph.D.
Christopher McCurry, Ph.D.
Teresa Piacentini, Ph.D.
Jessica Tarantino, Psy.D.
Brian Neville, Ph.D.

PSYCHIATRY
Mary-Ellen Diorio, M.D.
Allison Remmers, M.D.

EDUCATIONAL PSYCHOLOGY
Melyssa Higgins, Ph.D.

AUTHORIZATION FOR MUTAL EXCHANGE OF HEALTHCARE INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

CLINIC NAME:	ABCD INC.	NAME:	
ADDRESS:	155 NE 100th Street, Suite 306 Seattle WA 98125-8014	ADDRESS:	
PHONE:	206-569-3361	PHONE:	
FAX:	206-361-1598	FAX:	
EMAIL:	reception@abcdseattle.com		

This authorizes mutual exchange of information between the above entities. _____ (patient's initials)

PURPOSE OF DISCLOSURE: (check all that apply)

- ❑ Continuing Care
- ❑ Legal
- ❑ Other
- ❑ Referral
- ❑ Coordinate Care with Primary Care Physician
- ❑ Coordinate Care with School Personnel

SPECIFIC INFORMATION TO BE DISCLOSED: (check all that apply)

- ❑ Intake evaluation
- ❑ Psychiatric evaluation
- ❑ Educational evaluation
- ❑ Psychological evaluation
- ❑ Progress notes
- ❑ Medical information
- ❑ Treatment plan
- ❑ Behavioral observations
- ❑ Other

I UNDERSTAND THE FOLLOWING:

1. My records are protected under the Federal and State statutes and cannot be disclosed without my written consent unless otherwise provided for in the regulations. (42.CFR 431-300-431.307.42 CFR Part 2)
2. That I may refuse to sign this authorization
3. That the information released may be subject to re-disclosure and may no longer be protected
4. That I may revoke this consent, in writing, at any time except to the extent that action has already been taken.
5. This authorization for release of healthcare information **expires in NINETY (90 days)**, unless sooner revoked by me in writing
6. There may be charges associated with my request for records. Such charges shall not exceed the amounts allowable under RCW 70.02
7. That, when necessary, portions of my records may be faxed
8. A photocopy of my records may be faxed

ANY MINOR CHILD, 13 YEARS OR OLDER, HAS ALL THE RIGHTS PROVIDED BY CHAPTER 275-56 WAC TO CLIENTS RECEIVING OUTPATIENT SERVICES. THEREFORE, THESE MINOR CLIENTS MUST SIGN AUTHORIZATIONS FOR RELEASE OF CLIENT INFORMATION.

PATIENT (Signature)
(must sign if 13 years or older): X _____ DATE: _____

PARENT/GUARDIAN (Signature): X _____ DATE: _____

THIS AUTHORIZATION expires on _____ (90 days from the signed date)