Crystl Murray-Mills, MSW-*Behavioral Health Therapist*
900 N. Maple St., Suite 103, WA 99201 (509) 995-0682

CONSENT FORM

NOTICE TO CLIENTS: Crystl Murray-Mills can help you better if I am able to work with other agencies and professionals that know you and your family. By signing this from, you are giving permission for Crystl Murray-Mills and the agencies and individuals listed below to use and share confidential information about you. If you do not sign this form, I may still share information about you to the extent allowed by law. If you have questions about how I share client confidential information or your privacy rights, please consult Crystl Murray-Mills.

CLIENT IDENTIFICATION:

NAME	DATE OF BIRTH		TELEPHONE NUMBER
ADDRESS	**CITY**	**STATE**	**ZIP CODE**

CONSENT:

I consent to the use of confidential information about me to plan, and coordinate services, treatment, payment, and benefits for me or for other purposes authorized by law. I further grant permission to Molly Phillips and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally, or by computer date transfer, mail or hand delivery.

Check below those included in this consent in addition to POCCS, identify them by name or ID and address:

☐ Health care providers: ____
☐ Housing Programs: ____
☐ Schools: ____
☐ Department of Corrections: ____
☐ Hospitals: ____
☐ Others: ____

I authorize and consent to sharing the following records and information (check all that apply):

☐ My client records ☐ Health care information ☐ Treatment or care plans ☐ Individual assessments
☐ Records Listed: ____
☐ Payment records: ____
☐ Others (list): ____

PLEASE NOTE if your client records include any of the following information, you must also complete this section to include these records.
I give permission to disclose the following records (check all that apply):
☐ Mental Health ☐ Chemical Dependency (CD) services

- This consent is valid for 90 days, or until _______________ (date or event).
- I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
- I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.
- "A copy or fax is as good as an original" and is valid to give my permission to share records.
- I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the consent.
- I further understand that my health information specified above will be disclosed pursuant to this consent, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA Privacy law.

SIGNATURE	DATE	CONTACT WITNESS SIGNATURE	DATE

PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF REQUIRED)	TELEPHONE NUMBER (AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the : (attach proof of authority)
☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

NOTICE TO RECIPIENTS OF INFORMATION: If these records contain information about HIV, STDs or AIDS, you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the client, this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.