Sharon M. Dillinger, PhD, LMHC **Psychotherapy Services**
10202 Pacific Avenue S, suite 211 **tel: 253.548.8824**
Tacoma, WA 98444 **fax: 253.548.8824**

Patient Name: _____ DOB: _____

I hereby authorize Sharon M. Dillinger, PhD to:

- o EXCHANGE information with:
- o RELEASE my records to:
- o REQUEST my records from:

Person/Agency: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Please check all records that you would like exchanged, released or requested.

o Entire Medical File	o Academic Records/Classroom Reports
o Hospital Admission/Discharge Reports	o Medication Records
o Progress Notes (dates)	o Laboratory/Medical Test Results
o Psychological Testing Reports	o Probation/Parole Records
o Psychological Testing Raw Data	o Other:

If desired, provide additional information about this request.

_____

_____

Disclosure is for CONTINUITY OF CARE unless otherwise specified below.

_____

Specific Authorizations

I understand that my records may contain information regarding mental health diagnosis and treatment, drug and/or alcohol abuse, the testing, diagnosis, or treatment of HIV/AIDS and/or sexually transmitted diseases. I give my specific authorization for these protected records to be released. Any of these records that I do not want released are listed below.

You have a right to revoke this authorization in writing at any time by providing such written notification to Sharon M. Dillinger, Ph.D. However, your revocation cannot be retroactive if action has already been taken on the authorization prior to your revocation or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest the claim. I understand that neither Sharon M. Dillinger, PhD, my health plan, or other covered entity may condition treatment, payment, enrollment or eligibility of benefits upon my signing this authorization for release of information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPPA privacy rule. This release shall remain in effect for 90 days from the date of signature unless otherwise specified: _____

Signature: _____ Date: _____

Witness: _____ Date:_____