Healthy Decisions
WA State Certified DV Treatment
Anger Awareness & Management
Veterans' Transitional/Trauma Counseling

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RELEASE OF CONFIDENTIAL INFORMATION

DATE:___________________________

I, _____________________________________ give Healthy Decisions and the providers listed below my consent to release and exchange information regarding any matter relevant to my case:

Probation/Court _____________________________________Contact: ________________________
Address:____Phone No.: ___________________
Fax:_____________________________ email____

Children's Services: Contact:________________________
Address:____Phone No.: ___________________
Fax: ___________________email:____

Prior Domestic Violence Program:_____________________________
Address:_______________________________________ Phone No.: _______________
Fax: _____________ email:____

Mental Health Provider:____
Address:____Phone No.: ___________________
Fax: ___________________email:____

Attorney:____
Address:____Phone No.: ___________________
Fax: ___________________email:____

Other:____
Address:____Phone No.: ___________________
Fax: ___________________email:____

I understand that I have the right to revoke any part of this release at any time. This release will automatically expire one year from today's date. I intend that my authorization for the release of records and information related to my health care comply with and fulfill all requirements under the privacy standards (45 CFR Part 160) as implemented under Section 264 of the Health Insurance Portability and Accounting Act of 1996, P.L. 104-191 ("HIPAA").

Signed:____

PHONE NUMBER: