Street: 1207 N. 200th St., Ste. 101, Shoreline, WA 98133 ~ Mailing: 20126 Ballinger Way NE, 253, Shoreline, WA 98155-1117
425. 248.9224 ~ soulspaseattle@gmail.com ~ www.soulspaseattle.com

I _____ DOB: _____
authorize Danáe Ashley, LMFTA owner/member of Soul Spa Seattle, LLC to:

☐Obtain
☐ Release
☐Exchange

Information With:	Name:	Number:
☐ County Case Manager	_____	_____
☐ Psychologist/Therapist	_____	_____
☐ Psychiatrist	_____	_____
☐ Physician/Clinic	_____	_____
☐ Neuropsychologist	_____	_____
☐ Day Program	_____	_____
☐ Family	_____	_____
☐ Guardian/Conservator	_____	_____
☐ Other:	_____	_____
☐ Other:	_____	_____

The following information:
☐Discharge Summary
☐History and Physical
☐Consults
☐Neuropsychological/Psychological testing
☐Diagnosis
☐ Chemical Health Information
☐Case Plan/Notes
☐ Medications/Dosage
☐ Other: _____

Purpose for disclosure: _____
_____

Patient Restrictions on Methods for Disclosure:
I understand that communication of the items can occur:
Verbally In person conference Written questionnaire Mailed, Emailed, or faxed medical record / correspondence

I understand that:
* My health information is protected by federal regulation (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Soul Spa Seattle's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.

* I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Soul Spa Seattle, LLC's and Danáe Ashley, LMFTA's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.

* For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III)

* Communications resulting from this authorization will reveal that I receive services at Soul Spa Seattle, LLC and Danáe Ashley, LMFTA.

* Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Soul Spa Seattle, LLC and Danáe Ashley, LMFTA to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.

* This authorization may be used by Soul Spa Seattle, LLC, Danáe Ashley, LMFTA, and owned or managed programs upon transfer of my care to them.

Date: _____ Patient Signature: _____

Date: _____ Guardian Signature (if needed): _____

Date: _____ Staff Signature: _____

** Information to be 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.