Nicole Shiraev, MSW, LICSW, PLLC
http://www.shiraev-pllc.com
150 Nickerson Street, Suite 105, Seattle, WA 98109
Phone: (206) 496-2426 Fax: (206) 327-9169

AUTHORIZATION TO DISCLOSE (RELEASE) HEALTH-CARE INFORMATION

Identified Patient Information:

_____ _____
Patient Name Birth Date

_____
Patient's Mailing Address

_____
Patient's Physical Address (if differs from mailing address)

_____ _____
Patient's Daytime Phone Number Alternate Phone Number

Information May Be Disclosed By:

Nicole T. Shiraev, MSW, LICSW, PLLC, 150 Nickerson Street, Suite 105, Seattle, WA 98109
Phone: (206) 496-2426 Fax: (206) 327-9169

Information May Be Disclosed To:

_____
Name of provider, organization, or person to receive information and relationship to patient.

_____
Street Address, City State, and Zip (YOU MUST SUPPLY AN ADDRESS)

_____ _____
Daytime Phone Alternate Phone (If applicable)

_____
Fax (if applicable)

What kind of information do you want disclosed (copy fees may apply):

_____ Information from start of care (date: _____) to present (date: _____)

_____Information from specific dates of care (YOU MUST INDICATE DATES)
_____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

_____Specific Information (please specify): _____

Purpose of Health Information To Be Released?

____ Insurance _____Attorney _____ Doctor _____ Medical Leave

_____Personal _____Coordination of Care _____ Crisis Management

_____ Other (specify) _____

Check ALL that apply?

_____ I give permission for mutual exchange of information in writing.

_____I give permission for mutual exchange of verbal information.

_____Other (Specify) _____.

By signing below I understand that:

I am providing my expressed written permission to Nicole Shiraev, MSW, LICSW, PLLC to exchange information with the above mentioned party. I am aware that I may review my medical record with Ms. Shiraev prior to such information being released in order to ask questions and request addendum to the record.

Information in your mental health record may include physical health history, including medication information, physical health diagnoses (to include HIV/AIDS, sexually transmitted diseases). I give specific authorization for this information to be released.

Information in your mental health record will include relevant mental health diagnoses AND any relevant chemical dependency diagnoses that are assigned. I give specific authorization for this information to be released.

I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.

Once disclosed, health-care information may be subject to redisclosure by the recipient and may no longer be protected under health care information privacy laws.

_____

Signature of Patient, Parent, Legal Guardian, or Authorized Representative AND Date
***Documentation may be required to prove authority to sign on behalf of the patient.**

_____

Signature of Minor (Required for minors age 13-17) & Date
This authorization expires 90 days from the date signed OR on the date or event

indicated here_____

Applicable Fees:
>Applicable postage and cost of mailing supplies that exceed standard first class mail.
>First 10 pages free. If additional pages are printed, $0.25 charge applies.

Note: I am unable at this time to provide copies of records in electronic format. Paper copies only are provided.