

Lesli Desai, LICSW
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Patient Name

Date of Birth

Other Names Used

I authorize Lesli Desai, LICSW to:

- Exchange Information verbally with:
- Exchange information by email with:
- Send my treatment records to:
- Request records from listed provider

Name: _____
Address: _____
Phone: _____ or Fax: _____

My initials and signature below authorize the release of health care information relating to testing, diagnosis, and treatment for (please initial all that apply below)

_____ All clinic/medical/psychiatric/treatment records

OR _____ Release records for care provided on or during the period of _____

OR _____ Release records for this condition (specify) _____

Records in the following categories **MUST be initialed to be released:**

_____ Behavioral or mental health services

_____ Sexually transmitted diseases, antibody test results and related records, including pap smear results

_____ Contraceptives and pregnancy related records

_____ Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV)

_____ Drug / Alcohol diagnosis, treatment or referral information, including any drug or alcohol tests

_____ Other: Specify _____

_____ Do **not** release the following records _____

Purpose for release is continuity of care unless otherwise specified below:

_____ Billing insurance co/third party payer _____ Psychological Assessment _____ Information for legal process (i.e. subpoena or court order)

_____ Other: Specify _____

I have had explained to me and fully understand this request/authorization to release and/or obtain my information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. **I understand that I may take back this consent at any time**, except to the extent that action based on this consent has already been taken. I hold harmless Lesli Desai, LICSW and her agents or associates from any liability what-so-ever regarding the release of information contained in my file or concerning my evaluation or treatment to or from the above indicated individual(s). I further acknowledge that Lesli Desai, LICSW will not be able to insure the confidentiality of any information released from my file after such release. I understand that my records are protected under Washington State Law and cannot be disclosed without my written consent unless otherwise provided by law (RCW 70.02 & RCW 71.05). I understand that **no** report(s) contained in my **file received from other sources** can be released to me or others.

This authorization expires (required for release of records):

90 days from the dated signed On (date): _____ When the following event occurs: _____

(If left blank, this release will expire in 90 days after the termination of treatment)

X _____
Client Signature

DATE _____

X _____
Signature of parent or legal guardian (if client is under the age of 13)