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SEATTLE THERAPY
LESLI DESAI, LICSW

_____ Patient Name

_____ Date of Birth

_____ Other Names Used

I request Lesli Desai, LICSW, PMH-C to disclose:

- □ My healthcare information with:
- □ Send my treatment records to:
- □ Provider a Summary of Care
- □ Other _____

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 office/medical/mental health/treatment records, EXCLUDING psychotherapy notes
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_____ Release records for care provided on or during the period of _____
_____ Release records for this condition (specify) _____
_____ Other _____

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 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 disclose 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 revoke this consent at any time**. I hold harmless Lesli Desai, LICSW, PMH-C from any liability 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, PMH-C 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).

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 _____ DATE _____
Client Signature