Karen Tanzy, PhD
Clinical Psychologist
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206.579.3143

Authorization to Release Confidential Health Information

I authorize: ☐ Karen Tanzy, PhD

To exchange medical information with:

Name of Provider _____
Address _____
City/State/Zip _____
Phone _____
Fax # _____

To release the following information:

- ☐ A summary or statement containing dates of treatment
- ☐ A summary of treatment and progress
- ☐ Other: _____
- ☐ The designated information about me may be transmitted by fax, electronic mail, or other electronic file transfer mechanisms

To have discussions with the above individual for the purposes of:

- ☐ Coordinating and optimizing your ongoing treatment
- ☐ Transferring your care
- ☐ Other:_____

This authorization is valid for ninety (90) days from the date signed. I understand that by law I need not consent to the release of this information. However, I willingly choose to release it for the purpose(s) specified above. I understand that I can revoke this consent at any time, unless disclosure has already occurred in compliance with this consent.

This is strictly confidential material and is for the information of only persons who are professionally capable of understanding, appreciating, and acting upon it using their specific and advanced professional training in the mental health field. No responsibility can be accepted by the practitioner if it is made available to any other person who lacks such training, or who would not treat it in a professionally responsible manner, or who otherwise should not have access to it.

I certify that I have given consent freely and voluntarily for release of information and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____
Client Signature Date

_____
Printed Name of Client