Stephanie Washington Kuffel, Ph.D., P.S.
Licensed Clinical Psychologist
628 S. Maple St., Suite 101
Spokane, WA 99204
(509) 456-7888

Authorization/Release of Information Form

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize **Stephanie Washington Kuffel, Ph.D.** to release the following:

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Other (e.g., tests, bills), specify date(s): _____

Dr. Kuffel may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use
- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases

Dr. Kuffel may disclose this health care information to:

Name (or title) and organization: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____

This Authorization shall remain in effect until _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Kuffel's office address. However, my authorization will not be effective to the extent that Dr. Kuffel has taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

I understand that Dr. Kuffel generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party, such as in legal proceedings or workers compensation claims.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____	_____	_____
Signature of Patient	Printed Name	Date
_____	_____	_____
Signature of Partner (if applicable)	Printed Name	Date