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PEDIATRIC and ADULT PSYCHOLOGY

ASSOCIATES, L­­LC

 AUTHORIZATION FOR THE EXCHANGE OF INFORMATION

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient's Name Date of Birth

Hereby authorize Jeffrey R. Petra, Ph.D., to obtain information from and/or disclose information to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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INFORMATION AUTHORIZED AND REQUESTED: Unless otherwise specified below this authorization and request includes (1) all diagnoses and diagnostic assessments, (2) all treatment summaries and impressions, (3) the number and dates of sessions, (4) all mental health, medical and other health care information, (5) all cognitive, achievement or other psychoeducational test results, all IEPs and all other educational and behavioral information from schools, (6) all legal information, (7) all information obtained from third parties and (8) any other information which may be useful for evaluation & treatment.

Additional Information Authorized & Requested:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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DURATION: This authorization will remain in effect for one year unless otherwise specified below.

LIMITS (If no limits are specified this request/authorization has no limits on the information

requested/authorized for disclosure):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my records are protected under Washington state regulations, Chapter 275-56-240 WAC and Chapter 71.05 RCW, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This authorization addresses and permits the release of any and all medical information protected by the Drug Abuse Office and the Treatment Act of 1972 (P.L. 92.255), the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment Rehabilitation Act amendments of 1974 (P.L. 93.282), and Federal Regulations (CFR 42) which covers Drug and/or Alcohol Information Release. I also understand that my written consent is required to] release any information related to testing, diagnosis, and/or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This consent may be voided in writing at any time except to the extent that action has already been taken. This consent shall expire in one year unless updated or revoked prior to that date in writing. Photocopies and facsimiles of this authorization and signature are to be considered as valid as the original.

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Patient and Parent/Legal Guardian Signature Date