

Pamela Helberg, MA, LMHC
1116 Key St. #209, Bellingham WA 98225
Phone (360) 303-0671
Pamela.s.helberg@gmail.com

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Client Name: _____ Birth date: ____/____/____ SS#: _____
Previous Name(s): _____ Address: _____
Treating Provider: _____

Information is to be disclosed to and/or received from :
Name of Person/Agency: _____
Address: _____ Phone: (____) _____ Fax: (____) _____
For purposes of: ____ evaluation ____ treatment ____ forensic assistance ____ other: _____

I authorize Pamela Helberg to release my:
____ General Mental Health Record
____ Information related to chemical dependency/substance abuse
____ Psychotherapy Notes (the private content of your conversations with your therapist)
____ Information related to HIV/AIDS and/or sexually transmitted diseases
____ Other: _____

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this Authorization expires 90 days after the last dated signature.

Signature of Client Date

[90-Day Signature Updates]

Signature of Client/Parent/Guardian or Authorized Representative Date

Signature of Client/Parent/Guardian or Authorized Representative Date