CECILIA P MARGRET MD PhD MPH
Child, Adolescent and Adult Psychiatry
15127 NE 24th ST #139 Remond WA 98052, Phone/Fax: +1 (425) 305-3035, Email: contact@ceciliamargret.com

Authorization to Use and Disclose Protected Health Information (PHI)

Client name: _____ Previous name: _____ DOB _____

Address: _____

Phone number: _____ Email: _____

I, _____, hereby authorize the release of health care information
(name of client or client representative)

BETWEEN: Cecilia P Margret MD PhD MPH, Psychiatrist, 15127 NE24th ST #139 Redmond WA 98052, Phone / Fax: +1 (425) 305-3035

AND: Name and Organization: _____

Address: _____

City, State, Zip Code: _____

Phone/ Fax: _____

By signing this Authorization, I authorize the use and disclosure of all health information, including the following:

☐ All Health Information about me, including my clinical records. This information may include, if applicable:

Yes	No	
☐	☐	Information about mental health diagnosis or treatment.
☐	☐	Information on diagnosis or treatment for alcohol or drug use, abuse/, or dependence.
☐	☐	Information on HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).
☐	☐	Information about diagnosis or treatment of Sexually Transmitted Disease(s).

☐ Specific Health Information including only:

_____

_____

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For the Purpose(s) of: ☐ Continuity of care ☐ Client request ☐ Disclosure for legal purposes
☐ Other

This authorization ends: (check one box) ☐ in one (1) year ☐ when the following occurs:

I UNDERSTAND AND ACKNOWLEDLGE THAT: My records may contain information related to my mental health; my written consent is required to release any health care information related to testing, diagnosis, and/ or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and or drug and/or alcohol use unless otherwise allowed or required by law; this authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent; I may refuse to sign this authorization or revoke authorization in writing at any time, except to the extent that the action has already been taken in reliance of it; information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by this provider, office, or HIPAA regulation; and commencement, continuation, or quality of treatment will not be conditioned on whether I sign this document except insofar as PHI is necessary to assessment, report, or treatment contemplated by this authorization.

However, failure to sign here may result in a denial of insurance benefits by your insurer. PHI may be conveyed in writing, fax, or verbal/telephone communication. I have received a copy of my signed authorization.

I hereby release the provider and recipient of my PHI from any and all legal liability that may arise from the use and disclosure of information as set forth in this Authorization.

_____ _____ _____
Signature of client or legally authorized representative Date Time

Relationship if signed on behalf of the client by parent, legal guardian, personal representative, etc.