AUTHORIZATION TO OBTAIN OR RELEASE
PROTECTED HEALTH INFORMATION

I, _____,

(DOB: _____ SSN#_____-____-_____) authorize

Michael Sibrava, NCC, LMHC
Aletheia Therapetics, PLLC
901 Boren Ave.
Suite 701
Seattle, WA 98104
Ph: (206)473-2435 Fax: (206)832-4641

To ___ obtain and/or ___release protected health information concerning professional services that I have received to/from the following person or agency:

Name: _____

Organization: _____

Address: _____

_____

Phone: _____

The authorization I give is voluntary. The information to be released is to coordinate services to better meet my needs. I allow the following information to be released to that end.

___ Status Report
___ Diagnosis
___ Summary of Treatment
___ Lab Work
___ Psychological Evaluation
___ Other: _____
___ Psychiatric Evaluation
___ Legal issues/concerns
___ Physical Health Information
___ Medication Information
___ School Records/Evaluations

This authorization to release information expires in 1 year. This agreement may be revoked by myself at any time in writing. I understand that my records and healthcare information are protected by Federal and State laws and cannot be disclosed or re-disclosed without my consent unless otherwise provided by law.

Client Signature_____ Date:_____

Please forward any requested information to:
Aletheia Therapeutics PLLC, 901 Boren Ave., Suite 701, Seattle, WA 98104