Authorization for Disclosure & Exchange of Protected Health Information

I hereby authorize disclosure & exchange of protected health information described below, between the parties listed here:

Providers & Recipients of protected health information:

Walter Cardona, M.Ed.	
Cardona Counseling Services, LLC	
(206) 276-2116/ f. (206) 829-2401	
4500 9th Ave NE, Ste 300	
Seattle, WA 98105	

Revocation/Re-Disclosure:

Type of information to be Disclosed/Exchanged:

- ☐ BILLING/ADMINISTRATIVE INFORMATION
- ☐ Attendance and/or participation
- ☐ Specific information
- ☐ Progress Reports
- ☐ Evaluation/Assessment
- ☐ Clinical Observations

Purpose of Disclosure/Exchange:

- ☐ At client's request
- ☐ Coordination of treatment
- ☐ Department of Corrections
- ☐ Evaluation/Assessment
- ☐ Attendance and/or participation
- ☐ BILLING PURPOSES ONLY

It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment. I also understand that unauthorized re-disclosure by recipient(s) is a potential risk.

Duration:
If not previously revoked, this authorization will expire:_____

Conditions:
I understand that I have the right to refuse to sign this authorization; however, I also understand that refusing to do so may condition treatment by Cardona Counseling Services, LLC

Signature:
This authorization covers protected health information pertaining to: _____
PRINT NAME

Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of signature.

Signature	**Date**