Tango & Co.

Therapy

Where resilience and connection grow

Authorization for Release of Information

Tango & Co. Therapy | Carrie Soto Erickson, MS, LMFT

22443 SE 240th Street, Suite 202, Maple Valley, WA | License #LF00002191

This authorization complies with HIPAA (45 CFR §164.508), the Washington Health Care Information Act (RCW 70.02), and applicable federal and state mental health privacy laws.

1 Client Information

Full Legal Name: _____ **Date of Birth:** _____

Preferred Name: _____ **Pronouns:** _____

Address: _____ **Phone:** _____

2 Authorize Release FROM (Person / Organization Releasing Information)

Name / Practice: _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

3 Authorize Release TO (Person / Organization Receiving Information)

Name / Practice: _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

Relationship to Client: _____

4 Information to Be Released (Check all that apply)

General Records:

- ☐ Summary of treatment to date
- ☐ Progress / session notes
- ☐ Diagnostic / evaluation report
- ☐ Medication records
- ☐ Crisis / safety plan
- ☐ Intake / assessment records
- ☐ Treatment plan
- ☐ Discharge summary
- ☐ Billing / insurance records
- ☐ Other (describe below)

Special Categories *(These require specific authorization — check only what you wish to release):*

- ☐ Mental health / psychotherapy records
- ☐ Genetic information
- ☐ Psychotherapy notes (separately protected — HIPAA 45 CFR §164.508)
- ☐ HIV / AIDS-related information
- ☐ Sexual assault or domestic violence records
- ☐ Substance use records (42 CFR Part 2 — additional restrictions apply)

If 'Other' selected, please describe: _____

Date Range — From: _____ **To:** _____ ☐ All records on file

5 Purpose of Disclosure (Check all that apply)

- ☐ Coordination of care
- ☐ At the request of the client
- ☐ Insurance or billing purposes
- ☐ Disability determination
- ☐ Other (describe below)
- ☐ Continuing treatment / referral
- ☐ Legal / court proceedings
- ☐ Educational / school records
- ☐ Personal use by client

If 'Other', please describe: _____

6 Method of Disclosure

- ☐ Written / Mail: _____
- ☐ Fax: _____
- ☐ Secure Electronic Portal: _____
- ☐ Verbal (phone): _____
- ☐ In person / pick up: _____

Electronic transmissions will only be made via HIPAA-compliant, encrypted channels. Verbal disclosures will be documented in the client record.

7 Authorization Period

Date of Authorization: _____ **Authorization Expires:** _____

If no expiration date is specified, this authorization expires one (1) year from the date of signature or upon completion of the stated purpose, whichever comes first.

8 Right to Revoke

You have the right to revoke this authorization at any time in writing prior to its expiration, except to the extent that Tango & Co. Therapy / Carrie S. Erickson, LMFT has already acted in reliance upon it. To revoke, submit a written request to the address above. Revocation does not affect disclosures already made.

9 Re-Disclosure Notice

Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by HIPAA or Washington State law once received by a party not covered by those laws. **Exception:** Substance use disorder records released under 42 CFR Part 2 may not be re-disclosed without further written consent.

10 Voluntary Authorization

You are not required to sign this authorization. Tango & Co. Therapy will not condition treatment, payment, or eligibility for benefits on whether you sign this form, except as permitted by applicable law.

Client Statement & Acknowledgment

I understand that my health information is protected by federal law (HIPAA, 45 CFR §164.508) and Washington State law (RCW 70.02). I authorize the release of my confidential health information as described above. By signing below I acknowledge that:

- ☐ My consent is entirely voluntary.
- ☐ I may refuse to sign without affecting my treatment.
- ☐ I may revoke this authorization in writing at any time.
- ☐ Information released may no longer be protected once received by a third party.
- ☐ A copy of this signed authorization will be placed in my record.
- ☐ I am entitled to receive a copy of this completed form.

Client

Signature of Client	Date	Printed Name	Date of Birth

Personal Representative / Guardian (if applicable)

Signature of Personal Representative / Guardian	Date	Printed Name of Representative

Relationship / Authority of Representative (e.g., parent, legal guardian, power of attorney): _____