Aging Care Consultation Services
Karin Taifour, MA LMHC GMHS
206.999.5934, Fax 866.305.5149

P.O. Box 27612, Seattle WA 98165
Email karin@agingcareconsult.com
NPI 1740486431, WA Lic LH10799

Authorization to Exchange Protected Heath Information

Client Name: _____ DOB: _____

Address: _____ Phones: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below in order to coordinate my care. I understand this authorization is voluntary.

_____ authorizes KARIN TAIFOUR, *dba* Aging Care Consultation Services,
(Circle: Client/Patient/POA/Legal Representative) to exchange information with:

1._____

2._____

3._____

4._____

5._____

Unless otherwise indicated, my authorization includes the release and exchange of any and all records and information from _____ to _____ and includes any and all information related to any of the following: *(Strike through those you wish to exclude, if any, and initial at the end of the line.)*

- Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- Diagnosis and/or treatment regarding mental health issues
- Diagnosis and/or treatment of HIV/AIDS, including HIV antibody test results
- Genetic test results and/or related treatment

I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment.

I understand that I may revoke this designation and authorization at any time and in any manner sufficient to communicate an intent to revoke.

I understand that revocation of this authorization will not affect any action that any party took in reliance on this authorization before it received notice of my revocation.

Client Signature	Date	Legal Representative Signature	Date
Karin Taifour, MA LMHC GMHS	Date	Printed name of representative if signed above *(provide documentation for file)*	