Tyson D Bailey, PsyD

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19221 36th Ave W, Suite 208 • Lynnwood, WA 98036

_____ _____ _____
Patient Name Date of Birth Other Names Used

I authorize Tyson Bailey, PsyD to:

- ☐ Exchange Information verbally with:
- ☐ Exchange information by email with:
- ☐ Send my treatment records to:
- ☐ Request records from listed provider:

Name: _____
Address: _____
_____
Phone: _____ or Fax: _____

My initials and signature below authorize the release of health care information relating to testing, diagnosis, and treatment for (please initial all that apply below):

_____ All clinic/medical/psychiatric/treatment records
OR _____ Release records for care provided on or during the period of _____
OR _____ Release records for this condition (specify) _____

Records in the following categories MUST be initialed to be released:

_____ Sexually transmitted diseases, antibody test results and related records, including pap smear results
_____ Contraceptives and pregnancy related records
_____ Behavioral or mental health services
_____ Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV)
_____ Drug / Alcohol diagnosis, treatment or referral information, including any drug or alcohol tests
_____ Other: Specify _____

_____ Do not release the following records _____

Purpose for release is continuity of care unless otherwise specified below:

_____ Billing insurance company or third party payer _____ Psychological Assessment
_____ Information requested for legal process (i.e. subpoena or court order)
_____ Other: Specify _____

I have had explained to me and fully understand this request/authorization to release and/or obtain my information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. **I understand that I may take back this consent at any time**, except to the extent that action based on this consent has already been taken. I hold harmless Tyson Bailey, PsyD and his agents or associates from any liability what-so-ever regarding the release of information contained in my file or concerning my evaluation or treatment to or from the above indicated individual(s). I further acknowledge that Tyson Bailey, PsyD will not be able to insure the confidentiality of any information released from my file after such release. I understand that my records are protected under Washington State Law and cannot be disclosed without my written consent unless otherwise provided by law (RCW 70.02 & RCW 71.05). I understand that **no** report(s) contained in my **file received from other sources** can be released to me or others.

This authorization expires (required for release of records):

☐ 90 days from the dated signed ☐ On (date):_____ ☐ When the following event occurs: _____

(If left blank, this release will expire in 90 days after the termination of treatment)

X _____ DATE _____
Client Signature

X _____
Signature of parent or legal guardian (if client is under the age of 13)