



Sally McIntosh Stoehr, MA, LMFT

Licensed Marriage & Family Therapist

“Helping Children, Families & Individuals to more positive fulfilling lives.”

Mailing Address:
PO Box 318
Poulsbo, WA 98370

9431 Coppertop Loop
Suite 102
Bainbridge Island, WA 98110
sally@sallymcintoshstoehr.com

206-780-7822 or 206-251-0236
Fax: 866-813-2548

CONSENT FOR EXCHANGE OF INFORMATION RE: INSURANCE

I hereby authorize Sally McIntosh Stoehr, LMFT, to release information regarding the treatment of _____ (client name), as required by the following insurance company to process my claim:

I understand this disclosure may include mental health/psychiatric information. Check mark for the type of information to be disclosed (include dates when appropriate – limit request to the least information necessary for your purposes).

- Drug/alcohol information _____
- HIV/AIDS/STD information _____
- Intake, treatment plans _____
- Assessments, evaluations _____
- Doctor’s notes and labs _____
- Other (be specific) _____

This notice may accompany a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand I have the right to revoke this authorization at any time. The revocation must be in writing and presented to this entity. I also understand revocation will not apply to circumstances where state or federal regulation require access to information for specific incidents including, but not limited to, reporting incidents of abuse, neglect or domestic violence, reporting to a public health authority to prevent or control disease, emergency medical care, or court order.

CONSENT OF A MINOR: A minor client’s signature (13-17) is required in order to release information concerning care for behavioral/mental health conditions and/or alcohol/drug abuse issues. A minor client’s signature (14-17) is required in order to release information concerning care for conditions relating to the minor’s sexuality, including but not limited to AIDS/HIV, contraception, pregnancy and/or termination, sterilization and sexually transmitted diseases.

A COPY OR FAX SHALL BE CONSIDERED VALID IN LIEU OF ORIGINAL

This authorization will remain in effect for 90 days from the date of signature or less as specified: _____

Signed: _____

Client name: _____

Date: _____