

**CONSENT TO RELEASE PROTECTED HEALTHCARE INFORMATION**

ARNOLD M. WASHTON, PH.D.

Your Name (print clearly): \_\_\_\_\_

I authorize Dr. Arnold M. Washton and any of his associates who may be directly or indirectly involved in my care to disclose confidential information about me to the persons/agencies listed below. This confidential information includes, but is not limited to: my alcohol and drug use history, psychological/psychiatric history, medical history; family history, legal and financial status, treatment history, results of diagnostic tests, urine tests, and clinical progress reports; current or planned treatment I may receive; all aspects of my treatment and clinical progress; and, all other information deemed important by Dr. Washton to assist with my treatment and/or other personal or business matters including but not limited to insurance reimbursement, legal action, regulatory action, marital conflict, child custody, etc. *I authorize release of this information to the following persons, organizations, and/or agencies:*

\_\_\_\_\_ Your Initials: \_\_\_\_\_  
Your psychiatrist, psychologist, or other therapist (specify):

\_\_\_\_\_ Your Initials: \_\_\_\_\_  
Family members: (specify):

\_\_\_\_\_ Your Initials: \_\_\_\_\_  
Your attorney (specify):

\_\_\_\_\_ Your Initials: \_\_\_\_\_  
Others (specify):

\_\_\_\_\_ Your Initials: \_\_\_\_\_

I acknowledge that this consent can be revoked by me in writing and that I can do so at any time for any reason except to the extent that: (a) this information is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; (b) disclosure has already occurred; and, (c) any pending action already taken and/or in progress that relies on this disclosure.

Patient's signature: \_\_\_\_\_ Date signed: \_\_\_\_\_