Release of Information — Client Instructions

This fillable PDF is provided for convenience and is not legal advice. Complete all required fields, then print and sign it or apply a valid electronic signature using compatible PDF software. A typed name alone may not satisfy signature requirements.

Privacy and return instructions
Do not email a completed form. Return it through your secure Headway or SimplePractice client portal, or deliver it in person. The website does not collect, transmit, or store information entered in this PDF.

Client full legal name *

Date of birth *

Address

Phone

Email

1. Person or entity authorized to disclose information

- [ ] Ryan Schuster, Psy.D. / Schuster PsyD
- [ ] Other provider or entity named below

Name / organization

Address, phone, fax, and/or secure email

2. Person or entity authorized to receive information

Name / organization *

Address, phone, fax, and/or secure email *

3. Information specifically authorized for use or disclosure

- [ ] Initial evaluation / assessment
- [ ] Diagnosis and treatment recommendations
- [ ] Treatment plan
- [ ] Progress summaries and attendance
- [ ] Medication information relevant to coordination
- [ ] Psychological or neuropsychological testing reports
- [ ] Billing or insurance information
- [ ] Complete clinical record, excluding psychotherapy notes unless separately authorized

Date range (required if limiting by dates)

Other specific information and limits

Psychotherapy notes are not included in this authorization. A separate, specific authorization is generally required for psychotherapy notes.

4. Purpose and limitations on use

- [ ] Coordination and continuity of treatment
- [ ] At my request

Other specific purpose

Specific limitations on how the recipient may use the information

5. Sensitive information — separately authorize only what should be disclosed

Information in a checked category may be disclosed only if the client also enters initials beside that category.

- [ ] Mental health information **Initials**
- [ ] HIV/AIDS or sexually transmitted infection information **Initials**

6. Expiration — choose a date or event *

This authorization is incomplete without an expiration date or event. For California records, choose a period of one year or less unless you specifically request a later date permitted by law.

Expiration date

OR expiration event

7. Client rights and acknowledgments

1. I may refuse to sign. Refusal will not affect my ability to obtain treatment, payment, enrollment, or benefits except where authorization is necessary for a service provided solely to create information for disclosure.

2. I may revoke this authorization at any time by sending a written revocation to Ryan Schuster, Psy.D., Crown Plaza Building, Suite 406, 114 W Magnolia St, Bellingham, WA 98225, or through my secure client portal. Revocation will not affect action already taken in reliance on this authorization.

3. I understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA. Federal or state law may still restrict redisclosure of certain mental health, HIV/AIDS, genetic, reproductive health, or substance-use information.

4. I have the right to receive a copy of this signed authorization and instructions for obtaining additional copies.

5. I understand that additional or separate authorization may be required for psychotherapy notes, substance-use-disorder counseling notes, or use of records in legal or administrative proceedings.

8. Signature *

Client or personal representative printed name

Signature (handwritten or valid electronic signature) Date *

If signed by a representative, describe legal authority

Return the completed form securely

Upload through Headway or SimplePractice, or deliver it in person. Do not send

Ryan Schuster, Psy.D. / Schuster PsyD

Crown Plaza Building · Suite 406 · Fourth Floor
114 W Magnolia St · Bellingham, WA 98225
Phone: 213-259-3156 · NPI: 1619256914
CA PSY 29137 · WA PY61117866 · OR 4119 · PSYPACT Authorized

Drafting basis

This conservative template incorporates overlapping authorization elements from HIPAA and the cited California, Washington, and Oregon provisions. Laws and professional requirements can change, and special records can require additional consent. The practice should have qualified healthcare counsel or a compliance professional review the form before clinical use.

Official sources reviewed

HIPAA Privacy Rule authorization requirements, 45 CFR 164.508

https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/

California Civil Code § 56.11

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV&sectionNum=56.11

Washington RCW 70.02.030 and 70.02.040

https://app.leg.wa.gov/RCW/default.aspx?cite=70.02

Oregon ORS 192.566

https://www.oregonlegislature.gov/bills_laws/ors/ors192.html

42 CFR Part 2 final rule overview

https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/

Practice review fields

Reviewed by

Date

Notes / revisions required before use