Kambria Kennedy-Dominguez, LPC, LCDC



1350 N Buckner Blvd Ste 220, Dallas, TX 7518

AUTHORIZATION TO RELEASE HEALTH AND PERSONAL INFORMATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Name: | | | | | | |  | | | | Date of Birth: | | |  | | | | | | |
|  | | | | | | |  | | | | Social Security #: | | | |  | | | | | |
| I request and authorize | | | | | | | | | | Kambria Kennedy-Dominguez, LPC, LCDC | | | | | | | | | | to |
| release/obtain healthcare information of the client named above to/from: | | | | | | | | | | | | | | | | | | | | |
|  | | Name: | | | |  | | | | | | | | | | | | | | |
|  | | Address: | | | | | | |  | | | | | | | | | | | |
|  | | City: | | |  | | | | | | | State: |  | | | Zip Code: | | |  | |
| Phone: Fax: | | | | | | | | | | | | | | | | | | | | |
| This request and authorization applies to: | | | | | | | | | | | | | | | | | | | | |
| 🞎 Healthcare information relating to the following treatment, condition, or dates: | | | | | | | | | | | | | | | | |  | | | |
|  |  | | | | | | | | | | | | | | | | | | | |
| 🞎 All healthcare information | | | | | | | | | | | | | | | | | | | | |
| 🞎 Other: | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 🞎 Yes 🞎 No | | | | I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 🞎 Yes 🞎 No | | | | I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. | | | | | | | | | | | | | | | | |
| Client Signature: | | | | | | | |  | | | | | Date Signed: | | | | |  | | |
| Therapist Signature: Date Signed: | | | | | | | | | | | | | | | | | | | | |
| THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED. | | | | | | | | | | | | | | | | | | | | |