Fall 2023

We understand that you may be interested in school-based mental health therapy services through the Pullman Public Schools. The next step to obtaining services is paperwork completion. Please complete:

1. Student Information Form
2. Student’s Rights, Responsibilities, and Informed Consent
3. Informed Consent and Required Disclosures (4 pages)
4. Outpatient Services Agreement for Collaterals
5. Youth Symptom Checklist
6. Authorization to Release Protected Health Information
   a. to identified staff at your student’s school
   b. to any relevant providers – community-based therapist, psychiatrists, etc.
   c. to you (the student’s parent/guardian) if your student is 13 or older
7. Exchange of Information Form: Primary Care Provider

Please mail to or drop off these forms to your students’ school to the attention of School-Based Mental Health Services. If we haven’t scheduled already, once we receive the completed forms we will call you to schedule an intake appointment. Intakes are generally 45-60 minutes and include information gathering and initial treatment planning.

We understand that you may have questions about the process and the paperwork. We can talk through these questions at intake or you may call us at any time. The best way to reach us is through our direct work cell numbers (Dr. Viergutz: 509.592.7911 and Chey Cochran 509.553.3011); you may also leave a message with the school secretary.

Take care,

Jessica Viergutz, PsyD, LP, School-Based Mental Health Therapist  
Chey Cochran, MA, LMHCA, School-Based Mental Health Therapist  
Victoria Jones, MS, School-Based Mental Health Therapist Trainee
Date: __________________________  Referral Source: ______________________________________________

Student’s Full Legal Name: ________________________________________________________________

Date of Birth: __________________________ Client’s Sex: ________  Client’s Gender: ____________

Mailing Address: ____________________________________________  Phone: ______________________

Current School: __________________________  Grade: __________________

Is there a 504 plan or IEP in place? ______________________________________________________

Parent/Guardian’s Name: __________________________  Phone: ______________________

Address (if different from above): __________________________________________________________

Parent/Guardian’s Name: __________________________  Phone: ______________________

Address (if different from above): __________________________________________________________

Is there a Parenting Plan in Place? ______________________________________________________

Pertinent Medical Information

Primary Care Provider: __________________________  Last Exam: _____________________________

Office Name and Address: ________________________________________________________________

Current Medications  Dosage Schedule  Prescribed by
__________________________________________  __________________________________________  ________________

__________________________________________  __________________________________________  ________________

__________________________________________  __________________________________________  ________________

Personal Health History (circle all that apply)

Cancer  Head Injury  Seizure Disorder  Thyroid Disease  Alcoholism

Diabetes  Heart Disease  Skin Disorder  Ulcers  Anemia

Spinal  Ear, Nose, Throat  High Blood Pressure  Vascular/Circulation  Epilepsy

Stroke  Asthma  Gastrointestinal  Allergies  Suicide Attempts

Birth Defects  Kidney/Bladder  Surgery: ______________________________________________

Past Mental Health Treatment

Dates  Presenting Problem  Therapist/Location  Hospitalization?
__________________________________________  __________________________________________  ________________

__________________________________________  __________________________________________  ________________

__________________________________________  __________________________________________  ________________

Are there guns in the home? ________________________  Are they secured? ______________________

Emergency Contact Information

(written information indicates the person can be contacted in an emergency, without additional authorization)

Name: __________________________________________  Relationship to Student: __________________

Phone: ____________________  Phone: ____________________  Address: ____________________________
Therapy is a collaborative process that involves…

- Exploring the issues that brought you to therapy.
- Building a trusting relationship with your therapist.
- Deciding upon specific goals and objectives.
- Working toward these goals and objectives.
- Evaluating progress on a regular basis.

I understand that…

- I have chosen to receive therapy services and I may terminate therapy at any time, unless court ordered.
- Mental Health Services are run through the Pullman Public Schools’ Department of Special Services and thus staff with Special Services as well as school building principals, school counselors/psychologists, school nurses, and school secretarial staff are aware of which students work with Mental Health Services and general scheduling.
- School-based mental health services are provided during school hours and are not available during school breaks, including summer vacation. Although the school-based mental health therapist may provide referrals for continuation of therapy during summer vacation, it is ultimately my responsibility to establish care with another clinician.
- I will be considered discharged from school-based mental health services at the end of each school year. If desired, it is my responsibility to re-initiate school-based mental health services for the next academic year.
- There is no assurance that I will feel better. During the course of my treatment material may be discussed that is upsetting in nature. This is part of the therapy process and may be necessary to resolve my concerns.
- Texting and email are not a secure method of communication. Mental Health Services does not routinely use either of these forms of communication with clients. If I choose to utilize texting or email I accept the potential security risks.
- My therapist may be a graduate-level practicum student or LMHCA who engages in clinical supervision with independently licensed providers.
- Mental Health Services therapists do engage in peer supervision and consultation.
- Mental Health Services therapists are not forensic clinicians. They are ethically bound to not give opinion about custody or visitation in legal proceedings. In addition, letters in support of emotional support animals are beyond the scope of Mental Health Services and will not be written.
- If I choose to discontinue attending scheduled therapy sessions without discussion I may be considered discharged from Mental Health Services care after 2 weeks of no contact. I understand that not continuing recommended treatment may result in adverse effects.
- Records and information collected during my treatment will be held or released in accordance with federal and state laws regarding confidentiality of such records and information: therapists are required to report all cases of suspected abuse or neglect of minors or vulnerable adults and to report all cases where there exists a danger to self or others. There may be other circumstances in which the law requires my therapist to disclose confidential information.
- I understand that by meeting in person, I assume the risk of exposure to coronavirus. I agree to take precautions outlined by Pullman Public Schools and to notify my therapist if I test positive for COVID during the time of our work.

I have the right…

- To confidentiality under federal and state laws relating to therapy services.
- To be informed of and ask questions about my therapy including the qualifications of my therapist.
- To be a collaborative partner with my therapist in the development of treatment plans.

I am responsible for…

- Being on time for my appointments.
- To cancel appointments that I am unable to keep within 24 hours of scheduled appointment. Messages may be left, 24 hours a day. A pattern of no shows or late cancellations may result in denial of service.
- Notifying therapist of any change in home telephone number and address.

I have read and understand all of the above.

__________________________  _____________________  _____________________________________________________  
Student Signature                Date                  Parent/Guardian Signature            Date
Prior to beginning treatment, it is important for you to understand Pullman Public Schools’ approach to mental health therapy services and to be in agreement with your student’s confidentiality during the course of treatment. This information is in addition to the information contained in the Student Rights, Responsibilities, & Informed Consent form.

In order to authorize mental health treatment for your student, you must have either sole or joint legal custody of your student. If you are separated or divorced from the other parent, notify me immediately. Please provide a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your student. If you are separated or divorced from the student’s other parent, please be aware that we believe that all parents have the right to know, unless there are exceptional circumstances, that their child is receiving mental health services. In Washington State, an adolescent 13 years or older may authorize their own treatment and determine the scope of any release of information consent forms.

Providers
Jessica Viergutz-Cavagnetto, PsyD holds licensure as a clinical psychologist and is the senior mental health therapist for the Pullman Public Schools. Dr. Viergutz earned her doctorate in clinical psychology in 2003 with an emphasis in children and families. Since, she has worked in non-profit outpatient and residential treatment settings as well as in private practice. Dr. Viergutz joined the Pullman Public Schools with the creation of Mental Health Services in 2019. Dr. Viergutz supervises both Ms Cochran and Ms. Jones.

Chey (sh-ay) Cochran, MA holds licensure as a mental health counselor associate. She earned her MA degree in Counseling and Clinical Mental Health in 2022. In addition to completing an academic year-long practicum with Mental Health Services of Pullman Public Schools, her background includes working with neurodivergent youth and their families in individual, family and group therapy settings. She draws from person-centered, strength-based approaches and tailors sessions to client’s unique needs and values. Ms. Cochran receives clinical supervision from Dr. Viergutz.

Victoria Jones, MS is an advanced practicum student through the Clinical Psychology PhD program at Washington State University. She completed her BS degree in psychology with a minor in sociology at East Tennessee State University in 2020 and then her MS degree in clinical psychology at WSU. Her clinical interests are working with youth and their families about concerns related to anxiety, depression, trauma, and neurodevelopmental disorders like ADHD and autism. Ms. Jones receives clinical supervision from Dr. Viergutz.

Course of Treatment
Our first appointment, intake, allows me to gather information about presenting issues, for us to define initial treatment goals, and to determine whether the therapist-client relationship seems to be a good fit. If you decide to continue treatment beyond intake an individual treatment plan will be developed. If the parent/guardian is not present for this appointment, the student and I will use parental input from intake to help guide the treatment plan. This plan will include what is known at the time about the course of treatment and will be amended as appropriate during our work together.

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client as well as the particular problems you hope to address. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Therapy involves a large commitment of time and energy. If you have questions about my approach, let’s discuss them whenever they arise. If your doubts persist, I will be happy to discuss community-based mental health therapy options; services in the community would be at your own expense. If you choose to discontinue attending recommended therapy sessions without discussion you may be considered discharged from Mental Health Service’s care after 2 weeks of no contact. I may inform the referral source as well as Special Services of discontinuation of services.
Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees. One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child’s therapeutic progress. Ultimately, you decide whether therapy continues. If either parent decides that therapy should end (and your child is 12 and under), I will honor that decision, however I ask that you allow the option of having a closing session to appropriately end the therapeutic relationship. If your child is 13 years or older, the decision to terminate would warrant further discussion with your adolescent.

Parent/Guardian/Family Involvement
In the course of treatment, I may meet with the student’s parents/guardians either separately or together. Please be aware, however, that, at all times, my client is your student – not the parents/guardians nor any siblings or other family members of the student. If I meet with you or other family members in the course of your student’s treatment, I will make notes of that meeting in your student’s treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your student’s treatment record.

Mandatory Disclosures of Treatment Information
In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your student’s permission. I have listed some of these situations below.
Confidentiality cannot be maintained when:

- Students tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent/guardian or others of the disclosure, how serious I believe this threat to be, and to try to prevent the occurrence of harm.
- Students tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent/guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
- Students are doing things that could cause serious harm, even if they do not intend to harm themselves or another person. I will use my professional judgment to decide whether a parent/guardian should be informed.
- Students tell me, I learn that, or it appears that the student is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor’s Treatment Information to Parents
Therapy is most effective when a trusting relationship exists between the clinician and the client. Privacy is especially important in earning and keeping that trust. As a result, it is important for clients to have a “zone of privacy” where clients feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my process to provide you with general information about your student’s treatment, but to not share specific information your student has disclosed without your student’s agreement. This includes activities and behavior that you may not approve of but that do not put your student at risk of serious and immediate harm. If your student’s risk-taking behavior becomes more serious, then I will use my professional judgment to decide whether your student is in serious and immediate danger of harm. If I feel that your student is in such danger, I will communicate this information to you.
Even when we have agreed to keep your student’s treatment information confidential, it may be important for you to know about a particular situation that is going on in your student’s life. In these situations, I will encourage your student to tell you, and I will help your student find the best way to do so. Also, I may sometimes describe your student’s problems in general terms, without using specifics, in order to help you be more helpful to your student.

Disclosure of Minor’s Treatment Records to Parents
Although the laws of Washington State may give parents (of children 12 and under) the right to see any written records I keep about your student’s treatment, by signing this agreement, you are agreeing that your child should have a “zone of privacy” in their meetings with me, and you agree to not request access to your student’s written treatment records.

Parent/Guardian Agreement Not to Use Minor’s Therapy Information/Records in Custody Litigation
When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children and adolescents. Although my responsibility to your student may require my helping to address conflicts between the student’s parents, my role will be strictly limited to providing treatment to your student. This means, among other things, that you will treat anything that is said in session with me as confidential. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements. Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I may provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s).

Billing, Fee and Financial Information
Since services are provided through Pullman Public Schools there is no fee billed to you for services. However, if your student is on an Individualized Education Plan (IEP) Pullman Public Schools may access federal Medicaid reimbursement from the Washington State Health Care Authority (HCA). Most insurance companies require that I provide them with the client’s qualifying diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I may provide you with a copy of any records I submit, if you request it.

Contacting School-Based Mental Health
Dr. Viergutz and Ms. Cochran service the entire school district and work a Monday-Friday week; whereas, Ms. Jones is on site two days a week. We are often not immediately available by telephone. You may leave a confidential voicemail message on our work cell phones. We will return your telephone call at the first opportunity during school hours. If you are unable to reach us and it is an emergency, please call 9-1-1 or go to the nearest emergency department.

Notice
As required under Washington State law therapists must be registered or licensed with the Department of Health for the protection of public health and safety. Registration or licensure of an individual with the Department of Health does not include recognition of any practice standards, nor necessarily imply the effectiveness of any treatment. It is every client’s right to refuse or discontinue treatment at any time. It is the responsibility of clients to choose the provider and treatment modality which best suits their needs and purposes. In addition, licensed or registered therapists are required to inform clients of the purpose of the Counselor Credentialing Act (the law regulating counselors). The purpose of the Counselor Credentialing Act is (a) to provide protection for public health and safety; and (b) to empower the citizens of the state of Washington by providing a complaint process against those therapists who may have committed acts of unprofessional conduct. Clients of licensed or registered therapists in the State of Washington may file a complaint with the Department of Health at any time they believe a therapist has demonstrated unprofessional conduct. To obtain a list of actions considered to be unprofessional conduct or to file a complaint, contact the Department of Health, Business and Professional Administration, PO Box 9012, Olympia, WA 98504-8001, (360) 236-4700.
**Adolescent Client:**
By signing below, I acknowledge that I reviewed and received (upon my request) a copy of HIPPA Notice of Privacy Practices and Notice of Confidentiality of Alcohol and Drug Abuse Client Records form. I have read and understood the policies described above. If I have any questions as we progress with therapy, I can ask at any time.

Client’s Signature ______________________________________  Date___________________

**Parent/Guardian of Minor Client:**
By signing below, I acknowledge that:

- I have read and understood the policies described above.
- I reviewed and received (upon my request) a copy of the HIPPA Notice of Privacy Practices and Notice of Confidentiality of Alcohol and Drug Abuse Client Records form.
- It is my responsibility to reach out to my student’s therapist for treatment updates. I will refrain from requesting detailed information about therapy content, yet, I can ask to join therapy sessions.
- I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist’s professional judgment, unless otherwise noted above.
- I agree to not to request records in order to respect the confidentiality of my student’s treatment.
- I understand that in Washington State at the age of 13 adolescents have control of their mental health records and need to sign an authorization to release information form for the therapist to speak with their parents.

Parent/Guardian Signature ______________________________________  Date_______________

Parent/Guardian Signature ______________________________________  Date_______________
INTRODUCTION: Thank you for assisting in ________________________’s therapy. Your participation is important and is sometimes essential to the success of treatment. This document is to inform you about the risks, rights, and responsibilities of your participation as a collateral participant.

WHO IS A COLLATERAL? A collateral is usually a family member or friend who participates in therapy to assist the identified client. The collateral is not considered a client and is not the subject of treatment. Mental health therapists have certain legal and ethical responsibilities to clients; the privacy of the relationship is given legal protection. Since you are not an identified client you have less privacy protection. My primary responsibility is to my client.

PARENTS AS COLLATERALS: Clinicians specializing in the treatment of children have long recognized the need to treat children in the context of their family. Participation of parents, siblings, and sometimes extended family members, is common and often recommended. If you are participating in therapy with your child, you may be asked to examine your own attitudes and behaviors and make positive changes that will be of benefit to your child and family.

THE ROLE OF COLLATERALS IN THERAPY: The role of a collateral will vary greatly. For example, a collateral might attend only one session, either alone or with the client, to provide information to the therapist and never attend another session. In another case a collateral might attend all of the client’s therapy sessions and their relationship may be a focus of treatment. We will discuss your specific role in treatment at intake. You are expected to maintain confidentiality of the therapy sessions.

BENEFITS AND RISKS: Psychotherapy often engenders intense emotional experiences, and your participation may engender strong anxiety or emotional distress within yourself. It may also expose or create tension in your relationship with the client. While your participation can result in better understanding of the client or an improved relationship, or may even help in your own growth and development, there is no guarantee that this will be the case. Psychotherapy is a positive experience for many, but it is not helpful to all people.

MEDICAL RECORDS: No record or chart will be maintained on you in your role as a collateral. Notes about you may be entered into the identified client’s chart. The client has a right to access the chart and the material contained therein. For clients 13 years and older, you have no right to access the chart without the written consent of the identified client. You will not carry a diagnosis and there will be no individualized treatment plan for you.

RELEASE OF INFORMATION: The identified client is not required to sign an authorization to release information form to the collateral when a collateral participates in therapy. The presence of the collateral with the consent of the client is adequate. This provides some assurance that full consent has been given to the clinician for the client’s confidential information to be discussed with the collateral in therapy. Completion of the authorization to release information form is helpful to the clinician when receiving a telephone call from a collateral or when the clinician calls a collateral. When the client is 13 or older, in most instance the clinician cannot share information with a collateral without a completed authorization to release information form.

If you have questions about therapy, my procedures, or your role in this process, please discuss them with me. The best way to assure quality and ethical treatment is to keep communication open and direct with your clinician. By signing below, you indicate that you have read and understood this document.

_____________________________________________________

Parent/Guardian Signature

Date

_____________________________________________________

Parent/Guardian Signature

Date
Mental Health Services of Pullman Public Schools, Pullman, WA 99163
Youth Symptom Checklist

Student Name: __________________________ Date: __________________________
Form Completed by: __________________________ Relationship to Student: __________

Main reason for seeking help at this time: __________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Directions: Place an X in the appropriate response to represent severity of each symptom.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Not Present</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety: cling behavior, separation anxiety, preoccupation with anxiety topics, fear, phobias</td>
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<tr>
<td>Tension: nervousness, fidgetiness</td>
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<td>Depressive Mood: sad, tearful</td>
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<td>Feelings of inferiority: lacking self-confidence, puts self down, sense of inadequacy</td>
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<tr>
<td>Suicidal Ideation: thoughts of suicide</td>
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<tr>
<td>National Call/Text Hotline: 988</td>
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<td>Hyperactivity: excessive energy, constant motion</td>
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<tr>
<td>Distractibility: poor concentration, shortened attention span, overly reactive to noises/movements in surrounding</td>
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<tr>
<td>Appetite Changes: Increased or decreased</td>
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<tr>
<td>Sleep Difficulties: inability to fall asleep, intermittent awakening, shortened sleep time</td>
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<td>Hostility: angry or suspicious, verbal put down of others</td>
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<td>Uncooperative: negative, difficult to manage</td>
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<tr>
<td>Emotional withdrawal: unspontaneous relations to others, lack of peer interaction, low activity</td>
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<td>Blunted affect: deficient emotional expression of affect</td>
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<tr>
<td>Manipulative: lying, cheating, exploiting</td>
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</tbody>
</table>

Directions: Place an X in the appropriate response

Are you satisfied with your eating patterns? Yes No
Do you ever eat in secret?
Does your weight affect the way you feel about yourself?
Have any members of your family suffered with an eating disorder?
Do you currently suffer with or have you ever suffered in the past with an eating disorder?
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Mental Health Services of Pullman Public Schools, 240 SE Dexter St., Pullman, WA  99163
School-Based Mental Health Therapist: ________________________________ Phone: ______________

Client Name: ____________________________________________________________
Date of Birth: __________________________

By signing, I authorize and request that Mental Health Services of Pullman Public Schools therapist and/or administrative and secretarial staff release to the individual listed below my individually-identifiable protected health information.

Name of School and Identified Staff: ____________________________________________

Address/Phone: ________________________________________________________________________________________________________
____Pullman, Washington 99163________________________________________

Health information may be used or disclosed through this authorization as follows:
Check One:  ___ All health information about me, including my treatment records, created or received by this provider. This information may include, as applicable, information pertaining to my diagnosis or treatment for alcohol and/or drug abuse, mental health concerns, or HIV/AIDS.

___ All health information about me as directed in the preceding check box, excluding the following: ________________________________

___ Specific health information including only: ______________________________

I understand that the provider cannot guarantee that the recipient will not re-disclose my health information to a third party. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken prior to the revocation. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party.

This authorization expires in one year unless previously revoked or otherwise indicated here: ______________________________

____________________________________________________________________

Client Signature __________________________ Date __________________________

Parent/Legal Guardian Signature __________________________ Date __________________________

Signature of Witness __________________________ Date __________________________

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 further disclosure of this information unless 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 information to criminally investigate or prosecute any alcohol or drug abuse patient. See also the Washington code and other applicable laws.
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Mental Health Services of Pullman Public Schools, 240 SE Dexter St., Pullman, WA 99163
School-Based Mental Health Therapist: ___________________________ Phone: ____________

Client Name: ___________________________________________________________________
Date of Birth: ___________________________

By signing, I authorize and request that Mental Health Services of Pullman Public Schools therapist and/or
administrative and secretarial staff release to the individual listed below my individually-identifiable protected
health information.

Name: _______________________________________________________________________

Address/Phone: ___________________________________________________________________

Health information may be used or disclosed through this authorization as follows:
Check One: ___ All health information about me, including my treatment records, created or
received by this provider. This information may include, as applicable, information pertaining to
my diagnosis or treatment for alcohol and/or drug abuse, mental health concerns, or HIV/AIDS.

___ All health information about me as directed in the preceding check box, excluding the
following: ____________________________________________

___ Specific health information including only: ________________________________________

I understand that the provider cannot guarantee that the recipient will not re-disclose my health information to a
third party. I understand that I may revoke this authorization in writing at any time, except that the revocation
will not have any effect on any action taken prior to the revocation. I understand that I may refuse to sign this
authorization and that my refusal to sign will not affect my ability to obtain treatment, except when I am
receiving health care solely for the purpose of creating information for disclosure to a third party.

This authorization expires in one year unless previously revoked or otherwise indicated here:

__________________________________________________________

Client Signature ___________________________ Date ___________________________

Parent/Legal Guardian Signature ___________________________ Date ___________________________

Signature of Witness ___________________________ Date ___________________________

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 further disclosure of this information unless 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 information to
criminally investigate or prosecute any alcohol or drug abuse patient. See also the Washington code and other applicable laws.
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Mental Health Services of Pullman Public Schools, 240 SE Dexter St., Pullman, WA 99163

School-Based Mental Health Therapist: ______________________________ Phone: _____________

Client Name: ____________________________________________

Date of Birth: ____________________________

By signing, I authorize and request that Mental Health Services of Pullman Public Schools therapist and/or administrative and secretarial staff release to the individual listed below my individually-identifiable protected health information.

Name: ____________________________________________

Address/Phone: ________________________________________________________________________________

Health information may be used or disclosed through this authorization as follows:

Check One:  

___ All health information about me, including my clinical records, created or received by this provider. This information may include, as applicable, information pertaining to my diagnosis or treatment for alcohol and/or drug abuse, mental health concerns, or HIV/AIDS.

___ All health information about me as directed in the preceding check box, excluding the following: ________________________________

___ Specific health information including only: ________________________________

I understand that the provider cannot guarantee that the recipient will not re-disclose my health information to a third party. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken prior to the revocation. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party.

This authorization expires in one year unless previously revoked or otherwise indicated here:

___________________________________________________________________________________

____________________________________________  __________________________

Client Signature  Date

____________________________________________  __________________________

Parent/Legal Guardian Signature  Date

____________________________________________  __________________________

Signature of Witness  Date

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 further disclosure of this information unless 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 information to criminally investigate or prosecute any alcohol or drug abuse patient. See also the Washington code and other applicable laws.
Exchange of Information Form: Primary Care

Client Name: _________________________________ DOB: __________________
School: ______________________________________

Primary Care Provider:
Name: _________________________________ Phone: __________________
Address: __________________________________________

Please be advised that I saw a patient from your practice for a mental health evaluation.
Diagnostic Impressions: __________________________________________
Treatment Recommendations: _______________________________________

Please know, all School-Based Mental Health (SBMH) Services are discontinued at the end of each school year. Any client that wishes to resume services in the fall needs to contact their SBMH therapist for an updated intake. Please contact me via telephone with any questions or concerns.

Respectfully,

______________________________________________
School-Based Mental Health Therapist Trainee (If Applicable) Date

______________________________________________
School-Based Mental Health Therapist Date

Member Consent: I hereby authorize Mental Health Services of Pullman Public Schools to release and exchange protected health information with the provider listed above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent in writing at any time except to the extent that the practitioner which is to make the disclosure has already acted in reliance on it. I understand that my treatment is not conditional in any way on my consenting to this disclosure.

______________________________________________
Client Signature Date

______________________________________________
Parent/Guardian Signature Date

OR,
___ I do not consent to have my information shared with my medical provider.
___ I am not currently receiving services from a medical provider.

______________________________________________
Client Signature Date

______________________________________________
Parent/Guardian Signature Date