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Robyn Howisey, M.A.
Child & Family Therapist

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Authorization for Release of Information

Client:

Name: ______________________________

Date of Birth: ________________________

Social Security # _____________________

Phone: ______________________________

Parent/Guardian: _____________________

Release to/from Contact: (i.e. teacher, school, parent, physician)

Name: ___________________________________

Organization: ___________________________

Address:__________________________________

City, State, Zip __________________________

Phone: __________________________________

I Hereby Authorize Robyn Howisey, M.A./Therapist to: (please check)

- ❒ Receive information from Contact regarding Client
- ❒ Release information regarding Client to Contact
- ❒ Exchange information with Contact regarding Client

Information to be disclosed: (check all that apply)

- ❒ Intake evaluation
- ❒ Progress Reports
- ❒ Medical Records
- ❒ School Records/Reports
- ❒ Medications
- ❒ Treatment information
- ❒ Testing
- ❒ All
- ❒ Other ____

Yes/No _____(initial) Disclose records pertaining to chemical dependency

Yes/No _____(initial) Disclose records pertaining to AIDS

Information obtained or exchanged is for the purpose of:

- ❒ Treatment
- ❒ Coordination of care
- ❒ Other ____

This Authorization to Release Information shall expire one year from the date signed. At any time the client or parent/guardian (if client is under 13) may revoke this authorization. Applicable to RCW 70.02.030.

Signed: ____ ______________
(client) (date)

Signed: ____ ______________
(parent/guardian) (date)