



Robyn Howisey, MA, LMFT
Counseling for Children, Teens & Adults

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Authorization for Release of Information

Client:

Name: _____ Phone: _____

Date of Birth: _____ Social Security # _____

Parent/Guardian: _____

I Hereby Authorize Robyn Howisey, LMFT/Therapist to: (please check)

- Receive information regarding Client
- Release information regarding Client
- Exchange information regarding Client

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

Name: _____ Organization: _____

Address: _____

Phone: _____

Information to be disclosed: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> All | <input type="checkbox"/> School Records/Reports |
| <input type="checkbox"/> Intake evaluation | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Treatment information |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Testing |
| <input type="checkbox"/> 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)