Authorization for Release of Information

Client Name: _____ Phone: _____
Date of Birth: _____ SSN: _____

Release to/from (i.e. physician)

Name:_____ Organization:_____
Address:_____
Phone:_____

I Hereby Authorize George Rhodes MSW to: (please check all that apply)

Receive information regarding client_____
Release information regarding client_____
Exchange information regarding client_____

Information to be disclosed: (check all that apply)

All_____ Intake_____ Evaluation_____ Medications_____ Progress Reports____
Treatment Information_____ Medical Records_____ Testing_____
Other_____
Yes/No ____(initial) Disclose records pertaining to chemical dependency
Yes/No ____(initial) Disclose records pertaining to AID

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 may revoke this authorization by notifying the clinician. (RCW 70.02.030)

Signed: _____ _____
(Client) (Date)

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