

# Authorization To Release Information

Client Name	Client Date of Birth
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This is to authorize that the information specified below regarding the above person be disclosed between:

Fred Matheson, MA, LMHC* 7907 212 <sup>th</sup> St SW #103 Edmonds, WA 98026	<b>and</b>	_____ Person or Facility/Organization ----- Street _____ City State Zip Phone: _____ Attention: _____
Phone: 206.569.4937 Attention: _____		Phone: _____ Attention: _____

Specific Information to be Disclosed:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Intake Evaluation      | <input type="checkbox"/> Psychiatric Evaluations   | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> Discharge Summary      | <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Progress Notes     |
| <input type="checkbox"/> Treatment Plan         | <input type="checkbox"/> Medical History           | <input type="checkbox"/> Diagnosis Summary  |
| <input type="checkbox"/> Medications            | <input type="checkbox"/> Medical Diagnosis         | <input type="checkbox"/> Academic Testing   |
| <input type="checkbox"/> Billing/Financial Info | <input type="checkbox"/> Crisis Plan               | <input type="checkbox"/> Other: _____       |

I understand that my records may contain information relating to mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel this authorization at any time, except to the extent that the action has already been taken. Unless canceled earlier by me, this authorization will expire

- in ninety (90) days from the signature date.**  
 **at termination of the counseling relationship.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Client \_\_\_\_\_ Parent \_\_\_\_\_ Legal Guardian \_\_\_\_\_

\*Fred Matheson is a Licensed Mental Health Counselor in the state of Washington.