AUTHORIZATION FOR RELEASE OR EXCHANGE OF INFORMATION

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PATIENT FULL NAME: _____

DATE OF BIRTH:_____

I, _____ hereby authorize and direct
Your Name

_____ to:
Name of Person or Entity from which you are Requesting Information

(Please check which type of information exchange applies)

_____ Disclose the following information:
_____All records and assessment reports
_____Records pertaining to mental health treatment
_____ Other:_____

_____Exchange the following information:
_____Information pertaining to present and ongoing care of patient
_____Health or mental health history
_____Other:_____

TO/WITH Sarah Peregrine (Grin) Lord, PsyD; Clinical Psychologist

For the following purpose(s):___Collaborative care ___ Psychotherapy

____Other:_____

I understand that my records contain information regarding my mental health. This may contain information about substance abuse treatment. I give specific permission for this information to be released. I understand that my records are protected under Washington and Federal law and cannot be disclosed without my written consent unless otherwise provided for by law.

This authorization does not expire during the course of active treatment and remains effective until 90 days after termination of treatment with Dr. Lord; however, I understand that I may revoke this authorization in writing at any time.

Signed:_____ Date:_____

Print name:_____

Relationship to Patient:_____