

AUTHORIZATION TO RELEASE INFORMATION

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| Client Name | Client Birth Date and Social Security Number |
|-------------|--|

This is to authorize that the information specified below regarding the above person be disclosed between:

| | | |
|---|------------|---|
| Heather Wind, MSW, LICSW* 534 Westlake Ave N, Suite 240 Seattle, WA 98109 | and | _____ Person or Facility _____ Street _____ City State Zip _____ Phone: _____ _____ Attention: _____ |
| Phone: (206) 915-6474 _____ 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"/> Other: _____ |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Medical Diagnosis | <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.

Signature: _____ Date: _____
 Client _____ Parent _____ Legal Guardian _____

*Heather Wind is a Licensed Independent Clinical Social Worker by the State of Washington