Authorization to Release of Information

Client Legal Name: _____

Date of Birth: _____

Preferred Name/Pronoun: _____

Full Name and Address of individual/facility/agency:

Name: _____

Address: _____

_____

City: _____

Phone: _____

The following information from:

- ☐ Medical Records
- ☐ Intake/Treatment Summaries
- ☐ Psychiatric Evaluation Records
- ☐ Probation/Parole Reports
- ☐ Discharge Summary
- ☐ Mental Health Records
- ☐ Progress Notes/Reports
- ☐ Phone Contact
- ☐ Social Worker's Reports
- ☐ Substance Use Service Records
- ☐ Psychological Testing
- ☐ Academic Testing/Classroom Reports
- ☐ Contact with School Counselors
- ☐ Other:_____

Disclosure of information authorized herein is required for the following purpose(s):

- ☐ I hereby consent to the release of above information. I understand that such information cannot be released without my specific consent.
- ☐ I have been informed of the specific type of information requested, and if known the benefits and disadvantages of releasing the information. Also, I have been informed that treatment services are not contingent on my decision concerning this release.
- ☐ I give my consent voluntarily.
- ☐ A copy or fax shall be considered valid in lieu of the original.
- ☐ I may revoke this consent at any time but that will not affect information that has already been shared.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature : _____ Date: _____

Records obtained as authorized by this consent form information release will be maintained in accordance with state confidentiality regulations (WAC 275-57), which prohibit re-disclosure. By law, Tina Santiago is required to keep confidential all records of the identity, diagnosis, prognosis or treatment of consumers utilizing her services.