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Authorization to Release Information

I, _____, give permission for **Erika Baxter** to discuss my therapeutic progress with _____ and for him/her to share information about me as well.

His/her phone number is _____.

I do not want the following issues to be discussed:

_____

_____

Purpose for Disclosure:

This disclosure is for the sole purpose of the client's treatment, in order to collaborate with others that may be of help to the client. I understand that my records may contain information relating to mental health issues (per RCW 71.05.620). I understand that information used or disclosed in keeping with this authorization may not be protected by Federal Law and could be used or re-disclosed by the receiving party. I understand that I may cancel this release at any time, except to the extent that action has already been taken or if talking to this person is necessary for you if you are being harmed. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to receive treatment.

Signatures:

Client: _____ Date: _____

Therapist: _____ Date: _____