Flow | THERAPEUTIC ASSOCIATES

AUTHORIZATION TO RELEASE INFORMATION

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

Woodrow W. Pollock, LMHC
PO Box 2571, Vashon, WA 98070

and

Name:

Street:

City/State/Zip:

Phone:

Attn:

Information to be Disclosed:

Intake Evaluation	Psychiatric Evaluations	Laboratory Results
Discharge Summary	Psychological Evaluations	Progress Notes
Treatment Plan	Medical History	Other: _____
Medications	Medical Diagnosis	Other: _____

Specific inclusions/exclusions:

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