Gloria Dykstra, MA, LMHC
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2207 NE 65th Street
Seattle, WA 98115

Authorization For Release of Information

Client's Name: ____________________________________
Birthdate: ____________________________________

This will authorize:

Name of person or organization: ____

Phone: __________________________________
Address: __________________________________
____
____

To release to:

Name of person or organization: ____

Phone: __________________________________
Address: __________________________________
____
____

The following information (check one):

Medical records/information ________
Counseling records/information ________
Academic records/information ________

Only the following information: (specify dates of service or conditions)
____
____
____

For the purpose of:
____
____
____

AUTHORIZATION: I certify that this request was made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by notifying either of the above listed parties. I understand any request for revocation will not have any effect on any actions taken prior to its submission. I understand that if the entity authorized to receive the information is not a health plan or healthcare provider, the released information may not be protected by federal privacy regulations. This authorization will expire one year from the date of signature unless otherwise stated.

____ ____________________
Signature of client/patient or legal representative **Date**