AFFIRM
CONSULTING/COUNSELING
Michael Washburn

Release Of Information

Authorization for the Release and use of Protected Health Information

Please PRINT Patients Complete Legal Name:_____

Date of Birth: _____ Authorization Date : _____

My signature below hereby authorizes the sharing of my confidential protected health information, including but not limited to: psychotherapy notes, information shared in psycho-educational sessions; physchological exam and/or testing results; telephone conversations; treatment plans and medical records to the following individuals only (please complete with name, title, address and phone number of individual being given access to this information.

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This information will NOT be shared with my spouse, partner, or any other person or entity UNLESS AUTHORIZED by me above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions.

This authorization shall be valid for one year from Authorization Date above, or may be withdrawn at any time through a dated and signed written request made to my therapist.

Patients Signature: _____ Date Signed: _____

Printed Patients Name: _____

Therapists Signature: _____ Date Signed: _____

Printed Therapists Name: _____