Counseling and Life Management: CALM, Laura Doerflinger, MS, LMHC 8752 122nd Ave NE Kirkland WA 98033 206-300-2550

AUTHORIZATION TO RELEASE INFORMATION

I, **(name of client)** ______________________________, (hereinafter "client") hereby authorize **Laura Doerflinger, MS, LMHC** (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of client, including, but not limited to, therapist's diagnosis of client, to:

Name: ____
____
Address:____
____
Phone: ____
Email: ____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at **get@calmwithlaura.com or 8752 122nd Ave NE, Kirkland, WA 98033** to be effective.

This disclosure of information and records authorized by client is required for the following purpose: ____
The specific uses and limitations of the types of medical information to be discussed are as follows **(be as specific as you choose to)**:
____
____

Such disclosure shall be limited to the following specific types of information:
____
____

Therapist shall not condition treatment upon client signing this authorization and client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Washington law may protect such information.

This authorization shall remain valid until: ___________________________________

Client’s signature:__________________________________

Date: ___________________