Sheryl Adams, MSW/LICSW
Professional Counseling and Psychotherapy

5224 Olympic Dr NW Gig Harbor, WA 98335 | PO Box 2403, Gig Harbor 98335 | 253-514-9948

AUTHORIZATION TO RELEASE INFORMATION

Client Name (printed)	
Date of Birth	

This document is to authorize that the information specified below regarding the above person be disclosed between:	
Name	Sheryl Adams, MSW, LICSW
Facility/Organization	Sheryl Adams Counseling
Address	5224 Olympic Drive NW, Gig Harbor WA 98335
Phone	253-514-9948

And:	
Name	
Facility/Organization	
Address	
Phone	
Fax	

Purpose of Disclosure:
The type and amount of information to be used or disclosed is as follows:
[ ] Medication List [ ] Psycho-Social/Family History [ ] Most Recent History/Physical
[ ] Specialty Consults [ ] Treatment Plan [ ] Mutual exchange of verbal information to facilitate provider services
[ ] Other Information:

I understand that I have a right to revoke this authorization at any time. I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will be valid for the current episode of treatment. I understand that authorizing the disclosure of this health information is voluntary. I can refuse authorization. I understand that I may inspect information to be used or disclosed as provided in CFR 164.524. If I have questions about disclosure of my health information, I will speak with my provider. By signing this document, you attest that you have been provided with the above disclosure information and have read and understand this information provided.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Counselor/Witness Signature _____ Date _____