Authorization for Release of Information (ROI)

Heather Taylor Counseling Services
Snohomish, Washington

Client Name: _____ Date of birth: _____

Information to be released:

- ☐ Summary of treatment to date
- ☐ Report
- ☐ Other: _____

Purpose of Disclosure:

- ☐ Coordination of care
- ☐ Other: _____

Individuals authorized to make disclosure: _____

Individuals authorized to receive disclosure: _____

Method of disclosure:

- ☐ Written: _____
- ☐ Verbal: _____
- ☐ Electronic: _____

Today's date: _____ Authorization to expire: _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this authorization/permission at any time, except to the extent that it has already been shared based on this signed document.

Client Signature: _____

If client is a minor, signature of guardian: _____

Relationship to client: _____

Date: _____