Teri Wood, M.A., PLLC, LMHC

Mailing address: 11410 NE 124th St #459
Kirkland, WA 98034
VM: 206-755-0672 Email: twoodmapllc@protonmail.com
teriwoodcounseling.com

RELEASE OF INFORMATION (ROI) AUTHORIZATION
ADOLOCSENT

The age of consent for mental health counseling in Washington is 13. However, it is necessary to have some parent/guardian involvement in order to provide you the best care. By signing this, you (client) give your consent to release and/or exchange information relating to SCHEDULING and BILLING between therapist and the parent(s)/guardian(s) listed below:

I authorize:	To release information to:
Teri Wood, MA., PLLC	Name:
Mailing Address: 11410 NE 124th St #459	Address:
Kirkland, WA 98034	City, State:
Ph: 206-755-0672	Phone: ( )
	Fax: ( )

Additional Information I Choose to Authorize Release of:

______ Diagnosis/Diagnoses
______ Goals
______ Skills/tools learned
______ Note of appointments for school.
______ Crisis contract/plan
______ Verbal summary of session
______ Other: ____

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance above, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I understand that I may refuse to sign or revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider, except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan of health care provider, the information may no longer be protected by the federal privacy regulations
- **This authorization will expire one year from the date I sign below.** I may revoke this authorization at any time notifying my provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processes.

Authorization:

Signature of Client of Authorized Person: ____

Date: ____________________ Relationship if not client: ____

In case of an emergency call 911 or go to your local ER/ED
In case of a crisis call: (King Co) 1-866-427-4747, (Snohomish Co) 1-800-584-3578, National Suicide line 1-800-273-8255