

Teri Wood, M.A., PLLC, LMHC

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RELEASE OF INFORMATION (ROI) AUTHORIZATION

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

For continuity and collaboration of my care, information I choose to authorize release of is:

- | | |
|--|--|
| <input type="checkbox"/> Assessments, scales, test, results | <input type="checkbox"/> Skills/tools learned |
| <input type="checkbox"/> Crisis contract/plan | <input type="checkbox"/> Verbal progress report |
| <input type="checkbox"/> Diagnosis/Diagnoses | <input type="checkbox"/> Written summary of treatment thus far |
| <input type="checkbox"/> Goals | |
| <input type="checkbox"/> Notice of appointment dates and times | |
| <input type="checkbox"/> 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 abuse, 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