**Sam Poyta Counseling, PLLC**

Sam Poyta, MSW, LICSW
[www.sampoytacounseling.com](http://www.sampoytacounseling.com)

#503-732-0409; 19222 11th Ave NE

Shoreline, WA 98155

**Authorization for Release of Information**

Client’s Name:

Date of Birth:

Phone:

Release to/from Provider’s Name:

Agency/Clinic/Organization:

Address:

Phone:

Fax:

I hereby authorize Samantha Poyta, MSW, LICSW to: (please check)

Receive information regarding Client\_\_\_\_\_

Release information regarding Client\_\_\_\_\_

Exchange information regarding Client\_\_\_\_\_

Information to be disclosed (check all that apply)

All\_\_\_\_\_ Intake\_\_\_\_\_ Evaluation\_\_\_\_\_ Medications\_\_\_\_\_ Progress Reports\_\_\_\_\_

Treatment information\_\_\_\_\_ Medical Records\_\_\_\_\_ Testing\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes/No \_\_\_\_\_ (initial) Disclose records pertaining to chemical dependency

Information obtained or exchanged is for the purpose of:

Treatment\_\_\_\_\_ Coordination of care\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This Authorization to Release Information shall expire one year from the date signed.

At any time the client may revoke this authorization by notifying the Clinician. (RCW 70.02.030)

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Client Signature Date