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Ste. M
Wasilla, AK 99654
907.376.9091 ph.
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Playful Journeys Counseling Center

AUTHORIZATION TO RELEASE INFORMATION

Client's Name: _____ DOB: _____

*I request and authorize **Playful Journeys Counseling Center** to receive and/ or release my personal health information listed below to the following individuals:*

1) _____ _____
Name of Agency/Individual Phone

_____ _____
Address Fax

2) _____ _____
Name of Agency/Individual Phone

_____ _____
Address Fax

The following information is to be released:

( ) Verbal Information related to (specify) _____
( ) Treatment Summary
( ) Clinical Notes and Treatment plan (specify dates) _____
( ) Other _____

This information is to be released for the following reasons:

( ) Coordination of care / Billing
( ) Referral
( ) Court testimony or preparation
( ) Evaluation purposes
( ) Supervision or consultation

I understand that the information disclosed will be used solely in the manner that I have granted my permission. This release is valid from this date _____ and will be valid only through _____.

Also, I understand that I can revoke this agreement with expressed intent either verbally or in writing. I have a right to specify the information that is released and understand that it will be used solely for the purposes I have requested above.

_____ _____ _____
Signature of client Age Date

Signature of parent or guardian	Date
Signature of guardian ad litem	Date