AUTHORIZATION TO RELEASE INFORMATION

Client Name	Client Birth Date

This is to authorize that the information specified below regarding the above person be disclosed between:

Mark R. Hoagland, Ma, Cht.
6527 21st NE, #4
Seattle, WA 98115

Phone: (206) 525-5395

Attention: _____

_____
Person or Facility

_____
Street

_____
City State Zip

Phone: _____

Attention: _____

Specific Information to be Disclosed:

☐ Intake Evaluation	☐ Psychiatric Evaluations	☐Laboratory Results
☐Discharge Summary	☐ Psychological Evaluations	☐Progress Notes
☐Treatment Plan	☐ Medical History	☐Other: _____
☐Medications	☐ Medical Diagnosis	☐Other: _____

I understand that my records may contain information relating to mental health issues. I also understand that my written consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have been tested, diagnosed, or treated for any of these things, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. This authorization prohibits further use of disclosure of the information being released beyond the specific limits of this consent. I understand that I may cancel this authorization at any time, except to the extent that the action has already been taken. Unless canceled earlier by me, this authorization will expire in ninety (90) days from the signature date.

Signature: _____ Date: _____
Client _____ Parent _____ Legal Guardian _____

*Mark Hoagland is a registered Mental Health Counselor in the state of Washington.