Authorization to Release Information

Use one form for each person or organization you want me to share information with or receive it from.

CLIENT NAME

DATE OF BIRTH

I authorize Liziah Elizabeth Richards, MA, LMHC, Liziah Therapies, to

Share information with | Receive information from | Exchange information both ways with

NAME OF PERSON OR ORGANIZATION

ADDRESS

PHONE

FAX OR SECURE EMAIL

Information that may be shared

__ Dates of attendance __ Diagnosis __ Treatment plan and goals __ Progress summary
Intake or assessment Medication information | Verbal consultation only

OTHER, OR ANY LIMITS

Psychotherapy notes require a separate authorization that names them specifically. This form does not cover them.

Purpose

__ Coordination of care __ Insurance or payment __ At my request __ Legal

OTHER PURPOSE

This authorization ends

ON THIS DATE, OR UPON THIS EVENT

When no date or event is given, it ends one year from the date signed.

I understand

- I may revoke this authorization in writing at any time, except for information already shared in reliance on it.
- My treatment, payment, enrollment, or eligibility does not depend on signing this form.
- Once shared, information may be shared again by the person who receives it and may no longer be protected by federal privacy law. Washington law and federal rules for substance use disorder records may still limit further sharing.
- I may receive a copy of this form.

SIGNATURE (CLIENT, OR PARENT OR GUARDIAN)

DATE

WHEN SIGNED BY A REPRESENTATIVE: PRINTED NAME AND AUTHORITY TO ACT