**Sam Poyta Counseling, PLLC**

Sam Poyta, MSW, LSWAIC  
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Seattle, Washington 98117

**Authorization for Release of Information**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release to/from Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency/Clinic/Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Samantha Poyta, MSW, LSWAIC 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 Date