P. Roger Hillerstrom, M.A.
555 Dayton St., Suite C
Edmonds, WA 98020
425-774-4673
fax-425-774-0690

Authorization for Release of Information

Client's Name _____ Birthdate _____
(**Please Print)** First MI Last
Are records filed under another name? _____

Address _____ City/State _____

Zip _____ Phone Number _____

I HEREBY AUTHORIZE ROGER HILLERSTROM TO: ❑ release information to: ❑ and/or obtain information from:

Name _____

Address _____ City/State _____ Zip _____

Phone _____ Fax _____

I am requesting Roger Hillerstrom to release this information for the following reasons and subject to the following limitations: _____

I hereby consent to the release of the above information including records of HIV disease, mental illness, drug/alcohol abuse and/or sexually transmitted disease treatment. You are authorized to release to the person or entity above all information or medical records relating to diagnosis, testing or treatment of such disease(s) as specified above. I understand that such information cannot be released without my informed consent.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my psychologist's office address. However, my authorization will not be effective to the extent that Roger Hillerstrom has taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

I understand that Roger Hillerstrom generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

I understand that if not revoked, my consent will automatically expire 90 days from the date of my signature.

Client Signature _____ Date _____

Parental Request for Release of Child's Records

I hereby declare under penalty of perjury, that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such records.

PARENT OR LEGAL GUARDIAN _____ Date _____

Date sent/received _____ by _____ (6/06)