**BAINBRIDGE FAMILY COUNSELING**
**RELEASE OF INFORMATION**

Name: _____ DOB: _____

Address: _____

Phone (with area code): _____

If this Release is for information pertaining to your dependent child(ren), name of dependent child and date of birth:

_____

Persons or organizations authorized to exchange information or records:

Dianah Jackson, LMFT
LF 60872112
4699 Woodson LN Suite 319C Bainbridge Island, WA 98110
(206) 953.2810
Email: jackson.dianah@gmail.com

Name: _____

Address: _____

Phone: _____

Specific information to be used or disclosed (including dates if needed): _____

Reason for disclosure/purpose of disclosure: _____

This authorization will expire in 180 days or on: _____
Date

NOTICE to those receiving information: If these records contain information about HIV, STDs, or drug or alcohol abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.

Important Information About Your Rights

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time prior to the expiration date or event noted above by telling Dianah Jackson in writing.
- I may see and copy the information described on this form if I ask for it.

Signature and date: _____