Caitlin Connolly, MSW, LICSW
1229 Cornwall Ave. Suite 209 Bellingham, WA 98225
Tel.: (518)241-5812

Release of Information (ROI) Form

I, _____, DOB _____ authorize **Caitlin Connolly, MSW, LICSW** to release, obtain, and/or exchange information about me and/or my therapeutic process with:

_____
Name of person/organization

_____
Address and phone number

Specific information to be released and/or exchanged will pertain to or include:

___ Evaluation and Treatment ___ Current Medications

___ Therapeutic Progress ___ Discharge Planning

___ Other (Specify) _____

The above information will be used for the following purpose(s):

___Continuity of Care ___ Treatment Planning

___ Discharge Planning Other (Specify) _____

I understand my records may contain information regarding mental health diagnoses and treatment and my records are protective under federal and state statutes pertaining to confidentiality and cannot be disclosed without written consent unless otherwise provided for in the regulations. I give my specific authorization for this information to be released and discussed between above entities. I also understand I may revoke in writing this consent at any time per RCW 70.02.040. This consent if valid for one year from the date it is signed unless revoked or updated by me. A copy or FAX shall be considered valid in lieu of the original. Any Minor child thirteen (13) years or older has all the rights provided by Chapter 388-865 WAC to clients receiving outpatient services. Therefore, theses minor clients must sign authorizations for release of client information.

Executed this _____day of _____, 20 ____.

_____
Client Name(s) DOB

_____
Client Signature DOB

_____
Parent/Legal Guardian Signature (if under 13) DOB

_____
Therapist Signature Date