cassady kintner, LMFT

Release of Information Authorization Form

Client Name _____

Date of Birth _____ Sex _____ Phone _____

Address _____

_____

I authorize the following person/organization to release information as stated below from the patient health information record:

Information to be released between

Person/Organization _____

Street Address _____

Phone_____ Fax _____

and Cassady Kintner, LMFT.

I understand this consent will automatically expire either: ☐ two years from the date of signature, termination of treatment with Cassady Kintner, ☐ termination of treatment with Cassady Kintner, OR ☐ until _____ (date), and I may revoke this consent in writing at any time. I further acknowledge the information to be released and/or received was fully explained to me and this consent was given of my free will.

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

*Note: Clients under 13 years of age must have a legal guardian or parent also sign this form.

cassady@cassadykintner.com | cassadykintner.com
P 206.858.0247 | F 206.402.4682
2366 Eastlake Ave E, #436 | Seattle, WA 98102