

*Karen Noble-Newman, MA, LMHC & Lisa Ann Mikulencak, MA, LMHC, CMHS  
2366 Eastlake Ave. E., suite 413  
Seattle, WA 98102*

## **Release of Information Consent**

This consent is between Karen Noble-Newman, Lisa Ann Mikulencak and

Individual's Name: \_\_\_\_\_

Agency's Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Regarding: Client's Name: \_\_\_\_\_

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

For the purpose of \_\_\_\_ facilitating treatment and continuity of care  
\_\_\_\_ other (state reason) \_\_\_\_\_

**Please circle I, II, and/or III:**

**I. Verbal exchange of information: phone #: \_\_\_\_\_**

**II. Written Documentation being requested by K. Noble-Newman & L. Mikulencak:**

- \_\_\_\_ Progress Notes (indicate dates)
- \_\_\_\_ Medical History and Physical Exam
- \_\_\_\_ Psychiatric Evaluation
- \_\_\_\_ Psychological Evaluation
- \_\_\_\_ Psychosocial/Intake Assessment
- \_\_\_\_ Discharge Summary
- \_\_\_\_ Lab & X-ray Reports
- \_\_\_\_ Certificate of Immunization Status/Records
- \_\_\_\_ IEP (Individualized Education Plan)
- \_\_\_\_ Report Card/School Records
- \_\_\_\_ Other \_\_\_\_\_
- \_\_\_\_ Other \_\_\_\_\_

**III. Specific Authorization:** If my records contain information regarding diagnosis or treatment of mental illness, drug and/or alcohol abuse, HIV (AIDS virus), or sexually transmitted disease, I give my specific authorization for these records to be released.

My treatment is not conditional to the signing of this authorization. I understand that I may cancel this release, at anytime, except to the extent that action has already been taken. Unless I cancel earlier, this authorization will expire in 90 days from this signature date. (RCW 70.02.030)

Client's Signature (13years or older) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship of guardian to client \_\_\_\_\_