Julie Holt, MA LMHC
Julie Holt, LLC
2366 Eastlake Ave East, Suite 417, Seattle, WA 98102
Phone: 206-979-6764, Email: julie@julieholtcounseling.com, Website: www.julieholtcounseling.com

RELEASE OF INFORMATION REQUEST

I, ________________________________/________________/______________________
(Name) (Date of Birth) (Social Security Number)
Hereby authorize:

[ ] Julie Holt, MA LMHC (DBA Julie Holt, LLC) to disclose to:

____
(Name)
____
(Address)
____________________/___________________
(Telephone Number) (Fax Number)

AND/OR [ ] ____
(Name)
____
(Address)
____________________/_____________________
(Telephone Number) (Fax Number)

to disclose to Julie Holt, MA LMHC (DBA Julie Holt, LLC).
The following specific information and/or records are requested for coordination of care:
_______ Summary of Treatment and/or Discharge Records
_______ Copy of Intake, Diagnostic Information, and Progress Notes
_______ Medication Records
_______ Mutual exchange of both verbal and written information
_______ Other:
____
Warning: This disclosed information shall be kept confidential to the best of the provider's ability; however, in the event that the information is re-disclosed, the information is no longer protected by law. I understand that my records may contain information regarding mental health diagnosis and treatment, drug and/or alcohol abuse (Per 42CFR, Part 2), the testing, diagnosis, or treatment of HIV/AIDS and/or sexually transmitted diseases (Per RCW 70.24.105). I give my specific authorization for these protected records to be released. I understand that I may revoke this authority at any time, except to the extent that action has already been taken. To revoke this authorization, it must be in writing and submitted to Julie Holt, MA LMHC. I understand that Julie Holt, MA LMHC is prohibited from conditioning treatment, payment, or eligibility for services on my agreement to sign this authorization. Unless otherwise noted in my mental health record, this authorization will remain in effect until treatment ends.

Expiration date: (*write "none" if authorized to remain open for length of treatment*):_____________

Executed:

___________________ ________________________ ________________________
(Month/Day/Year) Client Signature Therapist Signature

Please return a copy of this release form with the requested information.