



Miri Arie, PhD

[www.SocialEndeavors.net](http://www.SocialEndeavors.net)

## AUTHORIZATION FOR RELEASE OR EXCHANGE OF INFORMATION

PATIENT FULL NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize and direct  
Your Name

\_\_\_\_\_ to:  
Name of Person or Entity from which you are Requesting Information

(Please check which type of information exchange applies)

\_\_\_\_\_ Disclose the following information:

\_\_\_\_\_ All records and assessment reports

\_\_\_\_\_ Records pertaining to mental health treatment

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Exchange the following information:

\_\_\_\_\_ Information pertaining to present and ongoing care of patient

\_\_\_\_\_ Health or mental health history

\_\_\_\_\_ Other: \_\_\_\_\_

TO/WITH Miri Arie, PhD; Clinical Psychologist

For the following purpose(s): \_\_\_\_\_ Collaborative care \_\_\_\_\_ Psychotherapy

\_\_\_\_\_ Other: \_\_\_\_\_

I understand that my records contain information regarding my mental health. This may contain information about substance abuse treatment. I give specific permission for this information to be released. I understand that my records are protected under Washington and Federal law and cannot be disclosed without my written consent unless otherwise provided for by law.

This authorization does not expire during the course of active treatment and remains effective until 90 days after termination of treatment with Dr. Arie; however, I understand that I may revoke this authorization in writing at any time.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_