Tel: 253.237.3405
Fax: 253.679.0488
circlecreek**therapy**.com

110 2nd St. SW, Suite 110
Auburn, WA 98001

Authorization to Release Information

Patient name:_____ DOB: _____

Full address:_____

I give permission for the exchange of information, regarding the client listed above, between Circle Creek Therapy and the people/facilities listed below. This includes medical records, clinic notes, school records and any pertinent information that will help in developing the client's treatment program.

Person/Facility: _____

Address:_____

City, State, Zip: _____

Phone and/or Fax: _____

Email: _____

Person/Facility: _____

Address:_____

City, State, Zip: _____

Phone and/or Fax: _____

Email: _____

_____ _____

Patient / Parent / Legal Guardian Date