DRAYTON FAMILY COUNSELING

RELEASE OF INFORMATION

Client:	Client DOB:
Client Phone #:	Client Address:
Parent/Guardian:	Guardian Phone #:

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following service provider is authorized to receive/disclose my Personal Health Information: (circle one)

Drayton Family Counseling 1316 King Street, Suite 4 Bellingham, WA 98229 **Fax #: 360-227-7460**	1. Carrie Cochran, MA, LMHCA Phone: 360-436-6288	2. Chris Cochran, EdD, LMHCA Phone: 360-358-3408

2. The following agency or individual may receive/disclose my Protected Health Information (PHI):

Agency/Organization	
Individual Name	
Phone Number	
Fax Number	
Street Address	
City, State, Zip	
Email	

3. Please check below to indicate each type of information to be disclosed:

_____ Mental Health Information _____ MH Clinical Impressions/Notes _____ MH Diagnostic Info
_____ Alcohol/Substance Abuse _____ Other: _____

4. I may revoke this authorization by notifying Carrie Cochran / Chris Cochran in writing. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

5. This authorization expires on _____. **If not otherwise specified, expiration is one year from the date signed below.**

_____ _____
Client Signature **Date**

_____ _____
Parent/Guardian Signature **Date**
(if client is a minor)