

Release or Receipt of Information (R.O.I.)

This form when completed and signed by you, authorizes Stefanie Robbins, M.A., L.M.H.C. to release and receive protected information from your clinical record to the person you designate.

I, _____, authorize Stefanie Robbins, M.A., L.M.H.C. to release the following:

Provide description of the information you are requesting be disclosed (Your description should be as specific and detailed as possible):

This information should only be released to the following (Provide the name or function, institutional affiliation, mailing address, email address, and phone number to whom the information is being release):

I am requesting Stefanie Robbins, M.A., L.M.H.C. to release this information for the following reasons, and subject to the following limitations:

This Authorization shall remain in effect until { }. However, I understand that this Authorization does not permit disclosure of future health care given more than 90 days from the date of this Authorization (unless this is for disclosures to insurance companies). If this Authorization does not contain an expiration date, the Authorization expires 90 days from the date of my signature.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the office address of Stefanie Robbins, M.A., L.M.H.C. However, my authorization will not be effective to the extent that Stefanie Robbins, M.A., L.M.H.C. has taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance and the insurer has the legal right to contest a claim. I understand that I have a right to a copy of this completed and signed form.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPPA Privacy Rule.

If the Authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Client:

Client Name (printed) _____

Client (signature) _____ Date _____

Provider:

Stefanie Robbins, MA, LMHC (signature) _____ Date _____

Washington Licensed Mental Health Counselor, License # 60507675

Stefanie Robbins, LMHC

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