AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give my permission to: **Kathleen A. Mathews, LICSW**

4959 Olson Memorial Highway

Suite B

Golden Valley, MN 55422-5159

PARENT/GUARDIAN PLEASE INITIAL ONE OF THE FOLLOWING OPTIONS:

_____ disclose to
_____ obtain/receive from
_____ exchange with

_____
(person or agency)

ATTN: _____

_____
(contact information)

_____

Parent/Guardian Please INITIAL which types of information to release:

_____ Diagnostic Assessment	_____ Medical Reports	_____ Recommendations
_____ Treatment Notes	_____ School Adjustment/IEP/Evals	_____ Discharge Summary
_____ Treatment Plan	_____ General Communication	_____ Summary of Contacts
_____ Psychological Testing	_____ Psychiatric Evaluation/Medication Information	

_____ Other: _____

_____ Electronic Communication: I consent to having Kathleen Mathews communicate with the above listed person/entity by means of electronic communication in addition to fax, phone, and in-person contact. I understand the risk to my Protected Health Information with the use of unencrypted electronic communication per Kathleen's Social Media/Text/Email Policy.

for the purpose of confidential use in services provided to:

_____ _____
(Name) **(Birthdate)**

1. I understand that client records are protected and cannot be disclosed without my written consent unless otherwise provided by law.
2. I understand information sent in response to this release will not be released to any other person or agency without the individual's specific written consent.
3. I understand that I can stop this release at any time by informing Washburn Center in writing of my wish to revoke the release. This consent will expire one year from the date of the signature unless terminated sooner or extended longer by written request.
4. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the party that receives it and the information may not be protected by Federal/State privacy laws.
5. I understand that I do not have to consent to this authorization; however it may affect my services if I do not give my consent.

_____ _____
(Signature of Parent/Legal Guardian/Adult) **(Signature of Child) – if applicable**

_____ _____
(Relationship to Child) – if applicable **(Date)**

_____ _____
Signature of Witness **(Date)**