



**PAUL BAXTER, L.M.H.C, M.A.**  
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### **Authorization to Release Information**

I, \_\_\_\_\_, give permission for **Paul Baxter** to discuss my  
therapeutic progress with \_\_\_\_\_.

His/her phone number is \_\_\_\_\_.

I do not want the following issues to be discussed:

\_\_\_\_\_  
\_\_\_\_\_

#### **Purpose for Disclosure:**

This disclosure is for the sole purpose of the client's treatment, in order to collaborate with others that may be of help to the client. I understand that my records may contain information relating to mental health issues (per RCW 71.05.620). I understand that information used or disclosed in keeping with this authorization may not be protected by Federal Law and could be used or re-disclosed by the receiving party. I understand that I may cancel this release at any time, except to the extent that action has already been taken. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to receive treatment.

#### **Signatures:**

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist: \_\_\_\_\_ Date: \_\_\_\_\_