Zane Behnke
LICSW, CDP

Authorization for Release of Information

Name: ______________________________ **Phone**: ___________________________

Date of Birth: ______________________**S.S #** ________________________________
Release to/from (i.e. physician)
Name: _____________________ **Organization:** _______________________________

Address: ____
Phone: ________________________

I Hereby Authorize Zane Behnke LICSW,CDP. to: (please check)

Receive information regarding Client

Release information regarding Client

Exchange information regarding Client

Information to be disclosed (check all that apply)

All____ Intake____ Evaluation____ Medications____

Progress Reports____ Treatment information____

Medical Records____ Testing____ Other ______________________________________
Yes/No ___(initial) Disclose records pertaining to chemical dependency
Yes/No ___(initial) Disclose records pertaining to AID

Information obtained or exchanged is for the purpose of:

Treatment

Coordination of care

Other____

____
This Authorization to Release Information shall expire one year from the date signed.
At any time the client may revoke this authorization by notifying the clinician. (RCW 70.02.030)

Signed: ____
(Client) (Date)

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