EASTSIDE MENTAL WELLNESS

Gale Dhaliwal, Ph.D.
13303 NE 175th Street, Suite A
Woodinville, WA 98072

Release of Private Health Information

Client name:	DOB:
Address:	Phone:

I give permission for Eastside Mental Wellness to release/receive information from:

Person or Agency: Address: Phone number: Fax/Email:

The following information regarding the client/family: (check box)

	Initial Assessment
	Information on Progress in Therapy
	Treatment Plan
	Medical Information
	Termination Summary
	Other:

For the purpose of:

	Coordination of Services
	To Assist in Evaluation
	To Provide Continuity of Treatment
	Other:

I understand that I can revoke this authorization at any time, except to the extent that action has already taken place. If not revoked at an earlier date, this authorization will expire one year from the date signed. I understand that the specific type of information to be disclosed may include a history of DRUG or ALCOHOL, ABUSE, or MENTAL HEALTH TREATMENT.

Client Signature Date

Witness Name & Signature Date