Brianna Longwell Psychotherapy
103 E Holly St. #202
Bellingham, WA 98225
(360) 927-9556

Release of Information for Disclosure of Mental Health Treatment Information—Minor Client

I, _____ (full name of parent/ legal guardian), on behalf of

_____ (name of minor client) whose date of birth is _____, authorize Brianna

Longwell Psychotherapy with Associates in Mental Health to disclose to, exchange, and/or obtain information from:

_____.

Description of Information to be disclosed (client initial by each item):

_____All information

_____Assessment

_____Diagnosis

_____Medical Information

_____Treatment Plan or Summary

_____Progress in Treatment

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Brianna Longwell at briannalongwellpsychotherapy@gmail.com or 103 E Holly St. #202 Bellingham, WA 98225.

Expiration
This release is valid* for (check one): ☐ 90-days ☐ one-year ☐ cessation of therapy services
*Minors aged 13 years and older have rights to privacy and supersedes ROIs signed on their behalf by their parent/guardian unless legal guardianship is in place; ROI will expire at midnight of the minor client's 13th birthday and will need to be recompleted by minor client using Adult ROI form even if birthday occurs before this current ROI expires.

Form of Disclosure and Redisclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate (verbal, in writing, electronically, etc.).

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____
Signature of Parent/Guardian/Personal Rep. Date

_____
Signature of Therapist Date