Heather J. Johnson M.A, L.M.F.T
Aspire, Inc.
677 Woodland Square Loop
SE Lacey, WA 98503
LF60032040

Authorization of Release of Information

I _____, understand that I may authorize Heather J. Johnson M.A, L.M.F.T to disclose my private health care information to a third party. I hereby authorize Heather J. Johnson to disclose my private health information as specified below.

The nature of the information to be disclosed is:

_____

_____

_____

_____

The information to be disclosed specifically does include (check all that apply):
□ psychotherapy notes
□ information related to substance abuse assessment and treatment

The information specified above will be disclosed to:

Name _____

Institutional/Agency Affiliation_____

This authorization of disclosure will expire on _____
(date or event)

I understand that if the disclosure is being made to a financial institution or to my employer for purposes other than payment, Washington State law requires this authorization to expire no later than one year after signing.

I understand that except as provided by applicable law, my signing of this authorization is not a waiver of any rights I have under other statutes, the rules of evidence, or common law, and that I have the right to revoke this authorization at any time.

I understand that Heather J. Johnson will retain the original or a copy of this authorization.

By signing this document, I am attesting that I have received, read, and fully understand and consent to the disclosures, terms, and conditions above.

_____ _____
Client signature Date

_____
Print Client Name