Julie Ambrose, MSW, LICSW
929 SW 152nd St.
Burien, WA. 98166
(206) 498-0425

Authorization for the Exchange/Release of Information

Client Name ______________________________ Date of Birth ______________________________

Guardian (if clt is under 18) ______________________________ Relationship to Client ______________________________

Phone number ______________________________

Address ______________________________

I, ______________________________, hereby authorize the exchange of information between Julie Ambrose, LICSW and the following person or organization:

Person or Organization ______________________________ Title ______________________________

Phone number ______________________________

Address ______________________________

The purpose of this exchange of information is (check all that apply):

_____ Coordination of treatment

_____ Client to see new therapist

This authorization is valid until ______________________________. If left blank this authorization is valid for one year from the date it was signed or upon termination of therapy, whichever occurs first.

I understand that I may revoke this authorization at any time by notifying in writing Julie Ambrose, LICSW.

______________________________ ______________________________
Client's Signature Date

______________________________ ______________________________
Guardian's Signature Date