

A Better Way Counseling Service, LLC

601 E. McLoughlin Blvd. Vancouver, WA 98663

Phone: 360-281-6824

Fax: 360-314-2908

Release of Information General Purposes

I, _____ Date of Birth _____
(Legal Name)

As of _____ authorize the following information to be exchanged between
(Date)

the below party and A Better Way Counseling Service, LLC:

(Please initial all that apply)

_____ Intake information

_____ Progress reports

_____ Discharge summary

_____ Treatment plan

_____ Dates of service

_____ Phone Contact

_____ Payment

_____ Other(s)

(Please specify other)

_____ and/or _____

(Person)

(Organization)

Address/City, State: _____

Zip Code: _____ Phone: _____ Fax: _____

Client signature: _____ Date _____

Witness signature: _____ Date _____

This release is valid for one year after completion or termination of designated treatment. A patient may revoke in writing a disclosure authorization to a health care provider at any time unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization. A patient may not maintain an action against the health care provider for disclosures made in good-faith reliance on an authorization if the health care provider had no actual notice of the revocation of the authorization. In compliance with WAC 388-60-0145 we will have to consider if the release is required for continuing your treatment program. If a required release is revoked we may terminate you from our program.

Robert Johnson, M.Ed., LMHC

Debbie Tomasovic, M.Ed./Ed.S., LMFT

Certified Domestic Violence Treatment Providers and Supervisors

www.abwcs.com