RELEASE OF INFORMATION FORM

For use of protected health information

KIM OLSON, MFT
INDIVIDUAL AND FAMILY THERAPY
LICENSE# MFT 35572

Patient Name	Date of Birth
Parent/Guardian (applies to patients under 18)	

I hereby consent to participating in therapy with Kim Olson, M.A., LMFT and understand that all information I provide is private, confidential and protected by law as described in the HIPAA Privacy Practices. When necessary to coordinate my healthcare, and as described in the HIPAA Privacy Practices, my protected health information may be obtained from and/or provided to my:

Insurance Company	Phone

PRIMARY CARE DOCTOR		
Name	Address	Phone
		Fax

OTHER DOCTOR (RELATIONSHIP)		
Name	Address	Phone
		Fax

PSYCHOLOGIST OR COUNSELOR		
Name	Address	Phone
		Fax

Kim Olson is hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Kim Olson. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates my understanding and acceptance of the above practices.

Patient Signature	Date
Parent/Guardian Signature	Date

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