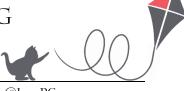
## JUNE PEDIATRIC CONSULTING

Holly Stafford DNP, ARNP, CPNP-PC Pediatric Behavioral and Mental Health Services



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## AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

This form authorizes Holly Stafford, DNP, ARNP to exchange (obtain, release, or share) protected health information regarding you/your child with the person or organization designated below. Please review and sign.

Organization/Person:	
This authorization pertains to clinical information	
Client's Name:	
Address:	
I,exchange (obtain, release, or share) the following	, authorize Holly Stafford, DNP, ARNP to information regarding myself/my child.
Medical History	Mental Status Exam
Medical Exam	Mental Health Treatment Plan(s)
Medical Records	Mental Health Progress Notes
Health Treatment Plan	Crisis Intervention Reports
Hospitalization Record	Educational Records
Discharge Summary	Drug/Alcohol Assessments/Records
Psychiatric Evaluation	Court/Agency Documents
Psychological/Neuropsychological Assessment Data/Results	
Client Signature:	Date:
The authorization below is given on the client's b	ehalf because the client is a minor or unable to sign.
Name: l	Relationship to Client:
Signature:	Date:

\*\*Patients aged 13-18 must sign this form to release information regarding mental health. This is required by Washington State and the parent's/guardian's signature is not acceptable.