LIMITED INFORMATION RELEASE

Not for use in forensic/legal cases

Name (please print) _____

Birth date _____ in (city) _____(state)_____

Currently residing at _____
(Street) *(City)* *(State & Zip)*

I HEREBY AUTHORIZE

Name(s) _____
(attorney, health provider, or therapist)

Address _____

Phone _____ Fax _____ E-mail _____

TO EXCHANGE INFORMATION ABOUT THE FOLLOWING

_____

_____

with

Diane W. DeWitt, PhD, ABVE, ABPP
12356 Northup Way, Suite 100 Bellevue, Washington 98005-1956
Telephone (425) 867-1500
admin@VocPsy.com

DECLARATION

I understand that Federal Confidentiality Regulations and Washington State Administrative Codes protect access to and use of my records and they cannot be disclosed without my written consent unless otherwise provided for in the regulations. See 70.02 RCW, RCW 70.02.030(3)f, RCW 70.02.040. I understand that I may revoke this release in writing at any time. I understand that Dr. DeWitt will keep this information confidential, except as authorized by me or by applicable regulations, and not release it to anyone else. I understand that I may revoke this consent at any time except to the extent that actions have already been taken based upon it. In any event, this consent expires automatically in 90 calendar days.

Dated _____

Signed _____

FAXED: _____
By *Date* *Time*

(Revised 06/30/15)