Steven Rothman, PhD
4655 161st Ave SE
Bellevue, WA 98006

RELEASE OF INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

APPROXIATE DATES SEEN BY DR. ROTHMAN: _____

I HEREBY AUTHORIZE THE RELEASE AND EXCHANGE OF INFORMATION BETWEEN:

Steven Rothman, Ph.D., Clinical Psychologist

AND:

_____

CONCERNING THE FOLLOWING:

All my psychological records, including information related to psychological and medical history and information related to the treatment Dr. Rothman has provided. This is to include informtion related to any use of alcohol and recreatinal drugs.

This authorization expires three months from date of signature.

SIGNED: _____

RELATIONSHIP TO THE PATIENT:

_____
(if the patient is younger than 14 years)

DATE: _____