KATHERINE YOST, PhD, LMFT
325 – 118th Ave SE Suite 210
Bellevue, WA 98005
425-405-0494

RELEASE OF INFORMATION

I hereby authorize Katherine Yost, PhD, LMFT

to contact _____
(Name)

_____
(Phone)

_____
(Address)

in order to ☐ Release ☐ Obtain

information regarding: _____
(Name of Patient)

for:
- ☐ Case Discussion
- ☐ Diagnosis
- ☐ Treatment
- ☐ Summary of Clinical History
- ☐ Records
- ☐ Psychological Tests
- ☐ Other _____

This authorization can be revoked at any time by the person signing below and will expire when treatment ends.

_____ _____
(Print Name) (Signature)

_____
(Address)

_____ _____
(Date)

(Relationship) ___Self ___Parent or Guardian

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