**GENERAL AUTHORIZATION FOR**

**RELEASE OF INFORMATION**

I,       , hereby grant the following organization to release the information described below from my records.

Name of organization:

Address:

City:       State:       Zip:

Release information to:

Name of organization:

Address:

City:       State:       Zip:

Information to disclose from my records:

Information will be used/disclosed as follows:

Signature Date of birth Date

Witness Signature Date

**This authorization is valid for 90 days from the date of signing.**

**The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.**