

**BRIAR ROSE CENTER: THE HOME OF HOPE & HEALING, P.L.L.C.**

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**Medical Information Release Form  
(HIPAA Release Form)**

**Name:** \_\_\_\_\_ **Date of Birth:**     /     /

**Release of Information**

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

**Spouse/Significant Other/Partner:** \_\_\_\_\_

**Child(ren):** \_\_\_\_\_

**Other:** \_\_\_\_\_

Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

**Messages**

Please call  My Home  My Work  My Cell Number: \_\_\_\_\_

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

text me on my cell phone

\_\_\_\_\_

The best time to reach me is  day  evening between the hours of \_\_\_\_\_

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date** \_\_\_\_\_