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Release of Information

I, _____, hereby authorize Erin K. Gist, MA, LMHC, CMHS to:

[ ] disclose information to [ ] receive information from [ ] exchange information with

Name/Agency name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Information to be disclosed:

[ ] History/Intake
[ ] Drug/Alcohol History
[ ] Progress
[ ] Treatment Summary
[ ] Current Medications
[ ] Discharge Summary
[ ] Attendance
[ ] Other: _____

For the purpose of:

[ ] Continuity of Care
[ ] Discharge Planning
[ ] Treatment Planning
[ ] Other: _____

I understand my records are protected under Washington state laws pertaining to confidentiality and cannot be disclosed without this written consent unless otherwise provided for in the regulations. I also understand I may revoke in writing this consent at any time per RCW 70.02.040.

This consent is valid [ ] For 90 days [ ] Until termination of counseling

[ ] Other: _____

Client Signature: _____ Date: _____

Name (Printed): _____ Date of Birth: _____

Parent/Guardian Signature (if under 13 years old): _____

Name (Printed): _____ Witness: _____