Connections Counseling Services NW
5900 - 100th St SW, Suite 17B
Lakewood, WA 98499
(253) 944-1014
https;//connectionscounselingnw.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Connections Counseling Services NW LLC by other individuals or agencies. Such requests should be referred to the original individual or agency. This release is for _____ DOB:_____. I am the: Client/Parent/Guardian for _____.

I _____ authorize Connections Counseling Services NW LLC to:

_____ release to:
_____ obtain from:
_____ exchange with

_____
_____
_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____ _____. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #:_____
Signature of Client Date