Bellevue Family Counseling, LLC
1601 116th Ave NE, Ste. 102 & 111
Bellevue, WA 98004
Main 425-947-5030
Fax 425-454-1476

Consent for release of information / mutual exchange of communication

I, ____, DOB ________________________
(Client/patient(s) full legal name(s)

do authorize: ______________________________Of Bellevue Family Counseling, LLC
(name of person exchanging information)

to release / exchange information with ____

____

the following information or documentation: ____
(specific text, nature of info or documents)

____

This information is to be used for the specific reason of: ______________________________
(i.e. continuity of care, treatment

____
planning, coordination of multi-disciplinary team, insurance eligibility, etc.)

This authorization expires ☐ 30 days after the end of treatment with Bellevue Family Counseling, LLC or on the following date: ___________________.

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that my consent is subject to written revocation by me at any time unless the person, organization, or Bellevue Family Counseling, LLC has already disclosed the information. (see Notice of Privacy Practices). Any minor child thirteen (13) years or older has all the rights of 275-56 WAC, therefore, must sign authorization for release.

This information shall be protected, by all communicating parties, under applicable Washington State and Federal (42 CFR) statues regulating Client/Patient confidentiality.

_______/_______/_________ ___________________________________
Date Client Signature

____________________________ ___________________________________
Provider Signature (witness) Client or Parent / Guardian Signature