Bellevue Family Counseling, LLC 1601 116th Ave NE, Ste. 102 Bellevue, WA 98004 Main 425-417-4700 Fax 425-454-1476

Consent for release of information and/or mutual exchange of communication

I,	, DOB
I,(Client/patient(s) full legal name(s)	
do authorize: (name of person exchanging informat	Of Bellevue Family Counseling, LLC ion)
acting in the capacity of:	, may release the (title or position relating to the client)
Following information or documentation:(spe	ecific text, nature of info or documents)
This information is to be used for the specific reason of: (i.e. continuity of care, treatment	
	(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:	
You may revoke this authorization in writing at any time, unless the person, organization, or Bellevue Family Counseling, LLC has already disclosed the information. (see Notice of Privacy Practices).	
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