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 _____
(Client/patient(s) full legal name(s)

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

acting in the capacity of: _____, may release the
(title or position relating to the client)

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: _____.

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