Meridian Counseling Services
13210 SE 240th St, Suite A-5, Kent, WA 98042 * (206)-291-8466

RELEASE OF INFORMATION

I, _____, hereby authorize

(Therapist) _____

To Release _____ To Exchange _____ information pertaining to my evaluation and/or counseling sessions with:

Name:_____

Address:_____

Phone:_____ Fax:_____

Description of Information to be released: _____

_____

Purpose of Disclosure:_____

_____

This authorization will expire on _____ or (90) days from the date of termination of my Treatment. I have been informed that I may revoke this authorization by written or oral communication at any time. I certify that this form has been fully explained to me and that I understand its contents.

_____ _____
Client Signature Date of Authorization

_____ _____
Witness Signature Date of Authorization