Meridian Counseling Services
13210 SE 240th St, Suite A-5, Kent, WA 98042

Release of Information Consent Form

I, _____, Authorize_____
(Client Name) (Therapist Name)

at Meridian Counseling Services to exchange information with the following person:

_____
Name, title

_____
Phone #, email address

To disclose the following information:

_____ Any relevant information ____ Treatment notes

_____ Information for billing purposes ____ Treatment plan information, treatment progress

____ Tasks completed in treatment ____ Full Disclosure document

_____ Other:_____

I understand that this authorization expires one year from the date it was signed, unless revoked in writing prior to its expiration

_____ _____
Signature of authorizing party Date

_____ _____
Signature of therapist Date