

Release of Information

I, _____ authorize **Jason Foster** to release, obtain, or exchange information about me and/or my therapeutic process with:

Name of person/organization

Address

Phone

Specific information to be released or exchanged will pertain to or include:

___ Evaluation and Treatment

___ Current Medications

___ Therapeutic Progress

___ Discharge Planning

___ Other (Specify) _____

The above information will be used for the following purpose(s):

___ Continuity of Care

___ Treatment Planning

___ Discharge Planning

___ Other (Specify) _____

I understand my records are protected under Washington state laws pertaining to confidentiality and cannot be disclosed without this written consent unless otherwise provided for in the regulations. I also understand I may revoke in writing this consent at any time per RCW 70.02.040. This consent is valid for ninety (90) days from the date it is signed unless revoked or updated by me.

Executed this _____ day of _____, 201__

Signature of Client _____

Signature of Witness _____