Jason Foster, MA, LMHC
316 NW 82nd Street
Seattle, WA 98117 (206) 504-3494

# 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

_____
Contact info

_____
Contact info

**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**_____