



# Client Release of Information

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RECOVERY GROUPS • THERAPY – MARRIAGE/FAMILY & INDIVIDUALS • SPIRITUAL DIRECTION

## PERMISSION TO REVIEW AND RELEASE CONFIDENTIAL INFORMATION

In accord with my legal right to confidentiality and privileged communication relevant to the services that I have received, I authorize and request

the disclosure of confidential information **from RCS** to the following individual:

confidential information be released **to RCS** by the following individual:

Agency/Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Telephone #: \_\_\_\_\_

any and all records summary report consultation

other \_\_\_\_\_

It is my understanding that this information will be used for: \_\_\_\_\_

This consent expires \_\_\_\_\_, unless revoked by me in writing at an earlier time.

I issue this authorization with knowledge of the contents of the material or communication and understanding of the consequences, and do so voluntarily and free from duress or undue influence.

I agree to pay a reasonable fee, if any, for the preparation of the materials and hereby hold harmless the above-named practitioner from any liability relevant to the release of the confidential information or privileged communication.

Client Name(s): \_\_\_\_\_ Date: \_\_\_\_\_

Social security #(s): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Client Signature(s): \_\_\_\_\_

Witness Signature: \_\_\_\_\_

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