Rebel Rise Counseling, PLLC
Mary M. Mills, MA, LMHC, SUDP
600 N 36th St, Suite 217, Seattle, WA 98103
Phone: 206-607-8866 | mary@rebelrisecounseling.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, _____ authorize Rebel Rise Counseling to:
(Print Name)

☐ Obtain information from and/or ☐ Exchange information with:

1. _____

2. _____

the following information pertaining to myself:

☐ Treatment Summary ☐ History/Intake

☐ Diagnosis ☐ Dates of Treatment/Attendance

☐ Other (Specify): _____

for the purpose of:

_____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event:

_____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____

Client Signature *Date*

_____

Counselor Signature *Date*