Rebel Rise Counseling, PLLC
Mary M. Mills, MA, LMHC, SUDP
600 36th Ave N Suite 315, 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 Rebel Rise Counseling 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:

_____

_____

_____

_____

the following information pertaining to myself:

☐ Treatment Summary ☐ History/Intake

☐ Diagnosis ☐ Dates of Treatment/Attendance

☐ Other (Specify): _____

for the purpose of:

☐ Evaluation/Assessment and/or Coordinating Treatment Efforts

☐ Other (Specify): _____

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).

Name: _____ _____ ____/____/_____
(Signature of Client) *(Today's Date)* *(Date of Birth)*

Name: _____ _____
(Signature of Witness) *(Today's Date)*