Consent for Release of Confidential Information

I, _____, authorize Patricia I. Curtis of Curtis Counseling

___ to receive information from _____

___ to disclose to _____

___ to exchange with _____

Information requested: (initial)

___ Termination Summary ____NONE

___ Psychological Report

___ Other: _____

Purpose: _____

_____ _____
Signature of Client Client date of birth

_____ _____
Witness Date of signing

I understand that the therapist may consult with my doctor or psychiatrist about my case. I understand that information discussed is for the purpose of treatment planning and/or counselor education and will remain confidential. I may cancel this consent at any time. Records will not be disclosed to others unless I direct it or the law requires or authorizes it. This authorization conforms with WAC 275 56-240 and Federal Regulation (CFR 42 Part 2).

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