CONSENT TO RELEASE

Betsy L. Hicks, MA, LMFT

Lacey Couple & Family Therapy Services, LLC
677 Woodland Sq Lp SE Suite 15 Lacey, WA 98503

Client's Full Name_____ Date of Birth___/___/___

Client's Full Name_____ Date of Birth___/___/___

Individual Record ☐ Couple Record ☐ Family Record ☐

If treatment involves a couple or family, each person age 13 or over needs to voluntarily authorize and provide written consent for comingled records to be released.

Reason/Purpose for Release: _____

I hereby authorize Betsy Hicks at Lacey Couple and family Therapy Services LLC to release/exchange the confidential information of, _____ to (Person(s) Authorized to Receive the Disclosure) _____

Address of recipient: _____
_____ Phone Number of recipient: ( )_____-_____

The information to be disclosed includes:

Dates Attended Therapy……☐ Treatment Received……..☐

All Mental Health Records…..☐ Other…☐ Specify _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon, and, if not revoked sooner in writing, the consent will expire on ____/____/____

I understand that my records may contain protected information and that my confidential information/records are protected under Washington State law (RCW 70.02 and RCW 71.05) and cannot be released without my written authorization unless otherwise stated by law.

I voluntarily authorize the release of my confidential information and records as directed above.

Signature of Client_____ Date of Signature_____

Signature of Client_____ Date of Signature_____

Therapist Signature_____ Date of Signature_____