Patrick Dougherty, MA, LMHCA
(Licensed Mental Health Counselor Associate)
3417 Evanston Ave N. Suite 315
Seattle, WA 98103 (360) 358-5679

RELEASE OF INFORMATION

I, _____ authorize **Patrick Dougherty** to release, obtain, or exchange information about me and/or my therapeutic process with:

_____
Name of person/organization

_____
Address

_____
Phone

Specific information to be released or exchanged will pertain to or include:

___Evaluation and Treatment ___Current Medications

___Therapeutic Progress ___Discharge Planning

___Other (Specify)_____

The above information will be used for the following purpose(s):

___Continuity of Care ___Treatment Planning

___Discharge Planning

___Other (Specify)_____

I understand my records are protected under Washington state laws pertaining to confidentiality and cannot be disclosed without this written consent unless otherwise provided for in the regulations. I also understand I may revoke in writing this consent at any time per RCW 70.02.040. This consent is valid for ninety (90) days from the date it is signed unless revoked or updated by me.

Executed this _____ day of _____, 201__

Signature of Client_____

Signature of Witness _____