St. Louise Counseling Services
141 156th Avenue SE
Bellevue WA 98007
425-614-6225

Client Authorization for Release of Information

Name of Client: _____

Birth Date: _____

I authorize:

Name of Disclosing Entity: _____
Phone Number of Disclosing Entity: _____
Address of Disclosing Entity: _____

to disclose information about me and my care beginning on: _____.

I also authorize Sarah Swenson, MA, LMHCA/Cathy Callans, MA, LMHCA to release information about my treatment beginning on: _____.

Information to be obtained: _____
_____
_____
_____
_____

Expiration of Authorization: This authorization will expire upon client's termination of psychotherapy with Sarah Swenson/Cathy Callans.

By signing, I acknowledge that I have read and agreed to the terms above:

Signature: _____

Date: _____

____Client Copy ____File Copy