Denise Hie, LMFT, LLC 425-478-4132; 855-736-5476 (fax)

RELEASE OF INFORMATION

This is your consent for your personal information contained within your clinical and medical records to be **disclosed and/or redisclosed to/from** the persons and/or agencies identified below for the following reasons:

- Planning and monitoring appropriate treatment.
- Case review and consultation with your physician and/or health care providers.
- Support and/or Involvement of family member(s) or significant other in treatment.

Your signature indicates that you authorize Denise Hie to release/receive/exchange information to/with the parties named below. You may revoke this consent at any time by providing written notice. Please refer to Denise Hie's Disclosure Statement for additional privacy information.

1. Name of any provider/agency that referred you:_____

   Address/Phone: _____

2. Name of primary ***physician*** (if different from above) or any providers in your care team who would benefit you in coordinating your care: _____

   Address/Phone:_____

3. Any other parties ***(i.e. school, attorney, community agency)*** that you authorize Denise Hie to release/receive/exchange information regarding your treatment:

   _____

   _____

4. ***Family member(s)/significant other*** who may participate in your therapy. Please indicate relationship to client.

   _____

   _____

*****Expiration date of this release of information, or indefinite:_____***

Print Client's Name: _____ DOB: _____Date:_____

Client's Signature (if 13 years or older): _____

Parent/Guardian Signature (if child is under 13): _____