



Catherine Hylen, MA, LMHC  
 Full Circle Counseling, PLLC 360-888-2783  
 1155 N State Street, Suite 608; Bellingham, WA 98225

**Release of Information**

I, \_\_\_\_\_ authorize Catherine Hylen to release, obtain, or exchange information about me and/or my therapeutic process with:

\_\_\_\_\_  
 Name of person/organization

\_\_\_\_\_  
 Phone

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City/State/Zip

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

- Evaluation and Treatment       Discharge Planning  
 Current Medications       Therapeutic Progress  
 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: \_\_\_\_\_