Elana Sabajon & Associates, LLC
...transforming your world one dialogue at a time...
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Release of Information

I, _____ authorize **Elana Sabajon** 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 contained in *The Law Relating to Counselors (18.19 RCW)*. This consent is valid for ninety (90) days from the date it is signed unless revoked or updated by me.

Executed this _____ day of _____, 2014

Signature of Client_____

Signature of Witness_____