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**Butterfly Hug Therapy**

**Kimberly Burke, LICSW** *WA License LW60682845*

*18978 front street ne - Poulsbo WA 98370 - 253***.***372.2412*

**CONSENT FOR EXCHANGE OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Kimberly Burke, LICSW at Butterfly Hug Therapy 18978 Front Street NE Poulsbo WA 98370 | 253-372-2412

to [\_] release information to and/or [\_] obtain information from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific Person Agency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Address City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone

This request and authorization applies to the following information to be communicated through phone, fax, email, or in person. (Check the type of information to be disclosed. Include dates when appropriate. Limit request to the least information necessary for your purposes).

[\_] Intake Assessment [\_] Discharge Summary [\_] Progress Notes

[\_] Treatment Plans/Goals [\_] Pertinent Medical Records [\_] Psychological/Psychiatric Evaluation

[\_] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of exchanging information is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

This authorization will remain in effect for the treatment period or when revoked or other time specified here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

My signature below indicates that I authorize the release of the above information and that I understand the following:

• This disclosure may include mental health/psychiatric information.

• I have the right to revoke this authorization at any time. The revocation must be in writing and presented to this entity. I also understand revocation

 will not apply to circumstances where laws require access to information for specific incidents including, but not limited to, reporting incidents of

 abuse, neglect or domestic violence, reporting to a public health authority to prevent or control disease, emergency medical care, or court order.

• My treatment, payment, enrollment, or eligibility for benefits is not conditional on me signing this authorization.

• There is potential for information disclosed under the terms of the authorization to be redisclosed by the recipient and no longer protected.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Legal Signature Legal Printed Name Date

If client is less than 13 years old, this release is signed by parent/guardian.

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**A COPY OR FAX SHALL BE CONSIDERED VALID IN LIEU OF ORIGINAL**