

Leslie Fields, LMHC

8752 - 122nd Ave. NE

Kirkland, WA 98033

425 503-3925

Consent for the Release or Exchange of Information

I, _____

residing at

hereby authorize Leslie Fields to contact _____

with regards to my child: _____

I understand that my child's records are protected under the Federal and State. Confidentiality Regulations. I also understand that I may revoke this consent at any time. And finally, I understand that my consent expires automatically in 90 calendar days after the date on which this form is signed, unless a specific date, event, or condition is of special exception.

Special conditions upon which this consent will go beyond 90 days are as follows:

I further acknowledge that the information to be released was fully explained to me and this consent is given voluntarily by me of my own free will.

Signature of client/Parent/Guardian

Date signed

Signature of Witness

Date signed