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CONSENT

FOR MUTUAL EXCHANGE OF INFORMATION

I hereby give "Consent For Mutual Exchange Of Information" between:

My Therapist:		and	The following Organization or Individual:	
YES	NO		NAME	PHONE NO:
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

...regarding historical and current information about the following clients:

Name:	Date Of Birth:
	____-____-____
	____-____-____
	____-____-____

What is the purpose of this "Consent For Mutual Exchange Of Information"?	CHECK ONE
PURPOSE: To Coordinate Treatment Services.	<input type="checkbox"/>
Or:	<input type="checkbox"/>

When will your "Consent For Mutual Exchange Of Information" expire?	CHECK ONE
You can choose to revoke this RELEASE OF INFORMATION at any time limited by the extent that action has already taken place. CONTACT US AT 360-336-3882 AND WE WILL DISCONTINUE THE RELEASE.	<input type="checkbox"/>
Or on this specific date: ____-____-____	<input type="checkbox"/>

Client Comment:

Your Comment:

Your signature below certifies your "CONSENT For Mutual Exchange Of Information" described above.

Client:		DATE:	____-____-____
Client:		DATE:	____-____-____
Client:		DATE:	____-____-____
Parent/Guardian:		DATE:	____-____-____
Parent/Guardian:		DATE:	____-____-____
Witness:		DATE:	____-____-____

SKAGIT FAMILY STUDY CENTER

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