

Bob Goettle, MA LMHC
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7812 Lake City Way NE
Seattle, WA 98115
206-372-8400 or 425-771-7036

Release Of Information

I, _____ for _____
(Date of Birth)

hereby authorize Noelle Mestres, MSW LICSW and Bob Goettle, MA LMHC to
 disclose to _____ and/or obtain from:

the following information:

-
- Initial Evaluation/Assessment/Diagnosis
 - Progress Notes (Skills Group and Individual)
 - Treatment Plans/Goals
 - Treatment Progress
 - Medications (current and past)
 - Drug/Alcohol
 - Medical History
 - Medical Diagnosis
 - Sexually Transmitted Diseases/AIDS/HIV
 - Other: _____

I understand that this consent is valid for 90 days from the date of signature. I may revoke it at any time. I understand that information may be re-disclosed as allowed by law only. I hereby release Bob Goettle, MA, LMHC and Noelle Mestres, MSW, LICSW from all legal responsibility or liability that may arise from the release of information and/or records.

Signature of Client: _____ Date: _____

Signature of Client: _____ Date: _____

Signature of Client: _____ Date: _____

Signature of Client: _____ Date: _____