Brian Kimmel, *MA LMHC*
Licensed Mental Health Counselor Associate #LH60993754

Client Name:_____Client Date of Birth:_____

I hereby authorize Brian Kimmel to obtain and/or release confidential information relating to my mental health and treatment to and/or from the following

[ ] Name/Role:_____

Address:_____

Phone / Fax Number:_____

[ ] Name/Role:_____

Address:_____

Phone / Fax Number:_____

I give specific authorization for the following types of information:

[ ] Entire File [ ] Psychotherapy Notes [ ] Treatment Plan [ ] Dates of Treatment
[ ] Other:

This authorization will be valid:

[ ] For one year from today's date
[ ] Until I terminate my counseling relationship with Brian Kimmel
[ ] Other:

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Brian Kimmel at 226 Summit Ave. E., Seattle, WA 98102. I understand that information released as a result of this authorization may be subject to re-disclosure by the receiving party.

_____ _____
Client Signature (date)

_____ _____
Witness Signature (date)

Brian Kimmel, MA LMHC
226 Summit Ave. E., Seattle, WA 98102
(360) 857-0318