

**Cynthia Benedict Goering, MA, LMHCA**

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Seattle, WA 98103

206.229.9114

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WA State Mental Health Counselor Associate License: MC60140954

**Consent to Obtain and Release Information**

Date: \_\_\_\_\_

To: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize you to release to and/or obtain from Cynthia Benedict Goering the following information (please check all that apply):

All Medical Records (please specify): \_\_\_\_\_

\_\_\_\_\_

All Psychological/Mental Health Records (please specify): \_\_\_\_\_

\_\_\_\_\_

All Court/Legal Documentation (please specify): \_\_\_\_\_

\_\_\_\_\_

Other (please specify): \_\_\_\_\_

\_\_\_\_\_

Please note: Information obtained pursuant to this consent is confidential. Further disclosure to other persons or agencies is forbidden by federal law without specific written consent of the client with the exception of quality assurance, peer review, supervision, fiscal audits, and compulsory process, where such information is kept confidential.

*This consent will expire 90 days after termination of treatment with Cynthia Benedict Goering. This consent may be revoked by me in writing at any time except to the extent that previous action has been taken. I understand no information can be obtained without written permission. I further acknowledge that the information to be obtained and the purpose for this consent was explained to me and that this consent is given of my own free will.*

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Witness's Signature

\_\_\_\_\_  
Parent/Legal Guardian's Signature (if client is under 18 years of age)