OptimalLife
WELLNESS CENTER

2320 130th Ave. NE, Suite 240, Bellevue, WA 98005
Phone: (425) 646-2778 • Fax: (425) 453-6377

CONSENT FOR THE EXCHANGE/RELEASE OF INFORMATION

I, _____, hereby authorize OptimalLife Wellness Center, to exchange/disclose my records or that of my child _____ with _____ and with _____.

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that my consent is subject to written revocation by me at any time. Any minor child thirteen (13) years or older has all the rights of 275-56 WAC, therefore, must sign authorization for release.

It is my wish that this consent will expire: _____.

Or, on this date: _____, ninety (90) days after the date on which this form is signed.

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

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Clinician Signature Date