Craig Stull, MA, LMHC, CDP
Psychotherapist
206.329.1660
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CONSENT FOR DISCLOSURE
and/or
EXCHANGE OF RECORDS AND INFORMATION

I (we) _____
Printed name(s)

a.k.a. _____ SSN: _____

hereby request and authorize CRAIG M. STULL, MA, LHMC, CDP *(WA State #LH00003470, #CP00003175)*, to

☐ make disclosure to ☐ receive information from ☐ participate in an exchange of information with the following individual or organization:

NAME: _____ PHONE: _____

ADDRESS: _____

_____

My initials indicate the types of information I am authorizing for disclosure, exchange and/or release.

INITIALS	TYPE OF INFORMATION TO BE RELEASED	TREATMENT DATES From	To
	Inpatient psychiatric information/summaries		
	Outpatient mental health and/or psychiatric information/summaries		
	Medical information		
	HIV/AIDS testing, diagnosis, or treatment		
	Information related to testing, diagnosis, or treatment of sexually transmitted disease		
	Drug, alcohol abuse treatment information		
	Information related to involvement with legal system		
	Other (specify)		

I understand that:

- The individual or organization listed above must have my written consent to share this information.
- Confidentiality of records is protected under State laws RCW 18.19.180 and 26.44
- This release expires 90 days after the date it is signed unless revoked by me in writing prior to this time.
- There may be charges associated with a request for documentation related to this release.

_____ Date:_____
Signature

DOWNTOWN OFFICE
1511 Third Ave, Suite 1000
Seattle, WA 98101

MAILING ADDRESS
PO Box 2862
Vashon, WA 98070

WEST SEATTLE OFFICE
9250 45th Ave SW
Seattle, WA 98136