Meaningful Journey Counseling
2208 NW Market St, Suite 407A
Seattle, WA 98107
(206) 745-3526

Couples Authorization To Release Information

I, _____ (hereinafter “Client 1") and _____ (hereinafter “Client 2") hereby authorize Rachel Orleck-Lubka, Psy.D. (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of both Clients, including, but not limited to, therapist's diagnosis of either Client (if applicable), to:

_____	_____	_____
Name/Organization	Address	Phone Number

_____
Fax Number

1. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at Meaningful Journey Counseling, 2208 NW Market St, Suite 407A, Seattle, WA 98017 to be effective.

2. This disclosure of information and records authorized by Client is required for the following purpose (such as continuation or coordination of care):

_____

3. This disclosure will include the following (e.g., medical record, treatment summary, written or verbal disclosure):

_____

4. The specific limitations information to be discussed are as follows (be as specific as you choose to):

_____

_____

Or if there are no specific limitations and Provider can use clinical judgment, please initial below:

_____ No limitations

This authorization shall remain valid until: _____(or a year from date signed).

_____	_____	_____
Client 1, Print Name	Client, Signature	Date of Birth
_____	_____	_____
Client 2, Print Name	Client, Signature	Date of Birth

_____
Today’s Date