

**AUTHORIZATION FOR THE MUTUAL RELEASE  
AND EXCHANGE OF CONFIDENTIAL INFORMATION**

**Paul David, Ph.D.  
103 East Holly St. – Suite 315  
Bellingham, WA 98225  
206-240-3162**

I hereby authorize the mutual written and verbal exchange of confidential information between Dr. Paul David and \_\_\_\_\_.  
Any exceptions to this exchange of confidential information are identified below.

I understand that without this release my records are otherwise protected under Federal and State regulations and cannot be disclosed except in accordance with those regulations. I further understand that it is my right to revoke this release at any time.

I agree that a photocopy of this form and my signature below is as valid as the original.

In consideration of Dr. David's agreement to perform this service for me, I hereby release Dr. David from all liability that might directly or indirectly result from the release or exchange of this information.

I understand and agree that this is a legally binding document, that I fully understand the rights and privileges that I now waive by signing this agreement, and that I give this release, authorization, and consent of my own free will.

Exceptions to this release \_\_\_\_\_

Check, if no exceptions.

Signed \_\_\_\_\_

Printed Name \_\_\_\_\_

Executed this \_\_\_\_\_ day of \_\_\_\_\_ in year of \_\_\_\_\_ in Bellingham,  
Whatcom County, Washington.