



THE HOPE CONNECTION

5319 SW WESTGATE DR. STE 113
PORTLAND, OR 97221

RELEASE OF INFORMATION

Client's Name: _____ Date of Birth: _____

I authorize _____ (therapist) to disclose to: _____

I authorize the following person/agency to disclose to _____ (therapist).

Person's Name: _____ Relation to Client: _____

Facility: _____ Phone: _____

Address: _____ Fax: _____

Items Authorized for Release: *Please check items to be released.*

- | | | |
|--|---|--|
| <input type="checkbox"/> Assessment/Assmt. Summary | <input type="checkbox"/> Treatment Plans/Progress | <input type="checkbox"/> Developmental History |
| <input type="checkbox"/> Referrals/Recommendations | <input type="checkbox"/> Admission Summary | <input type="checkbox"/> Medical Information |
| <input type="checkbox"/> DSM Diagnoses | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Physical/T.B. Test Result |
| <input type="checkbox"/> Presence in Facility | <input type="checkbox"/> Psych. Evaluation & History | <input type="checkbox"/> Educ./Emp./Voc. History |
| <input type="checkbox"/> Benefits Information | <input type="checkbox"/> Dates of Service for Billing | <input type="checkbox"/> Other: _____ |

Purpose of Disclosure of Information:

- | | |
|---|--|
| <input type="checkbox"/> to provide for client's current needs | <input type="checkbox"/> to help meet client's educational/employment/
vocational goals |
| <input type="checkbox"/> legal matter: probation and monitoring | |
| <input type="checkbox"/> billing | <input type="checkbox"/> continuum of care |
| <input type="checkbox"/> other | |

Means of Release:

- Verbal Email Mail Fax Hand-Carried

Records obtained as authorized by this consent for information release will be maintained in accordance with Federal confidentiality regulation (42 CFR, 2), which prohibits further disclosure without written consent to the person to whom it pertains.

Copies of this release are as valid as the original. This release may be revoked in writing at any time except for the extent already relied upon in good faith.

Client or Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____