

Elaine Davis, LMFT

Marriage and Family Therapist

503-402-8654

DavisElaineJ@gmail.com

3000 NE Stucki Ave #230

Hillsboro, OR 97124

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

This form, when completed and signed by you, authorizes me to release protected information or authorizes another to release protected information to me.

I, _____ and _____
(Name of client) (Name of client)

Authorize Elaine Davis, LMFT to __, __ Exchange __, __ Receive only __, __ Release only
(initial those that apply)

the following information:

Please INITIAL all that apply

____, ____ Counseling treatment/progress/ Assessment/Impressions	____, ____ Academic attendance, behavior, performance
____, ____ Attendance	____, ____ Other- Specify
____, ____ Medical Information	_____

with/to the following individual or agency:

(Name of individual/doctor/counselor/agency)

Phone number Fax number

- I understand that this information may be disclosed orally or in writing for 2 months after I end counseling.
- I understand that my records are not subject to further disclosure without my written consent.
- I may revoke this authorization at any time by giving written notification to my provider.
- A revocation will not affect any action already taken because of the authorization prior to the revocation. (Any disclosure made prior to that revocation cannot be undone)

(Signature of client) Date

(Signature of client) Date

(Signature of Parent or Guardian) Date