###### AUTHORIZATION TO RELEASE INFORMATION

Mary Chambers, LCSW

541-601-0616 Fax: 541-779-2390

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Mary Chambers, LCSW to \_\_\_\_\_disclose information to, or \_\_\_\_\_obtain information from:

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO CLIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Description of Information to be Disclosed

Please initial to indicate your consent

\_\_\_\_\_ Assessment

\_\_\_\_\_ Diagnosis

\_\_\_\_\_ Psychosocial Evaluation

\_\_\_\_\_ Psychological Evaluation

\_\_\_\_\_ Psychiatric Evaluation

\_\_\_\_\_ Treatment Plan or Summary

\_\_\_\_\_ Current Treatment Update

\_\_\_\_\_ Medication Management Information

\_\_\_\_\_ Presence/Participation in Treatment

\_\_\_\_\_\_Nursing/Medical Information

\_\_\_\_\_ Educational Information

\_\_\_\_\_ Discharge/Transfer Summary

\_\_\_\_\_ Continuing Care Plan

\_\_\_\_\_ Progress in Treatment

\_\_\_\_\_ Demographic Information

\_\_\_\_\_\_Psychotherapy Notes\*

(\*Cannot be combined with any other disclosure)

\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to this information being disclosed:

\_\_\_\_\_verbally

\_\_\_\_\_in written form

\_\_\_\_\_electronically

\_\_\_\_\_any of the above, consistent with applicable laws.

#### Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by submitting written notification to Mary Chambers, LCSW. I further understand that a revocation of the authorization does not pertain to information that has already been disclosed, prior to the revocation.

Expiration

Unless sooner revoked, this consent expires on \_\_\_\_\_\_\_\_\_\_\_\_\_\_or 30 days after the termination of treatment, either planned or unplanned.

Redisclosure

I understand that any information disclosed Mary Chambers, LCSW will not be disclosed to another party without my written consent.

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Signature of Patient/Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent, Guardian or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist Date