***Elaine Davis**, LPC, LMFT* **503-402-8654**

Marriage and Family Therapist

DavisElaineJ@gmail.com

3000 NW Stucki Pl. #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 J. Davis, LPC, LMFT to ○ Exchange ○ Receive only ○ Release only

the following information:

Please INITIAL all that apply :

_____ Mental Health/Psychiatric Diagnosis,

____Counseling treatment/progress/ Assessment/Impressions

____ Medical Information

____ Attendance

_____ Academic (attendance, behavior, academic performance

_____ Other- Specify

____

____

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