

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION\*

## Family Institute, P.C.

**Mail:** 4110 Pacific Ave., Suite 202  
Forest Grove, OR 97116

**Phone:** 503.357.9548

**Tigard Office:** 9735 SW Shady Ln., Suite 304  
Tigard, OR 97223-5481

**Fax:** 503.357.1158

Client's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

I, \_\_\_\_\_, authorize, Independent Practitioner, \_\_\_\_\_,

at Family Institute, P.C., **[to release] [request] [share]** confidential medical record information **[to] [from] [with]**:

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

The requested information to be released shall consist of:  Duplicated records concerning treatment and/or education.  
 Verbal consultation about treatment and/or education.

The specific information requested consists of:  Medical History  Social History  Psychiatric Evaluation  
 Discharge Summary  Psychological Evaluation  Educational Evaluation  
 Master Treatment Plan and Reviews  Other:

The information is needed for the purpose of: \_\_\_\_\_

This authorization may be revoked at any time by the patient. The revoking of this authorization shall not cancel any prior action that has already transpired.

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release the hospital, its directors, physicians, and employees and the above-named organization from any and all liability that may arise from this action whether or not foreseen at present. I understand that certain medical records (including any alcohol and drug abuse information\*\*) may be protected by Federal Regulations. \*\*Drug Abuse Office and Treatment Act of 1972 21 U.S.C. 1175; Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian for client under 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness++

\_\_\_\_\_  
Date

++VERBAL CONSENT: Two witnesses' signatures are required to show that the client expressed consent but is unable to provide signature at this time.

## \*PRIVACY ACT STATEMENT

1. The authority for soliciting this information comes from 10 USC 3012.
2. The purpose for soliciting the information is to provide the therapist/counselor data to assist in counseling you are seeking.
3. The information will be maintained under strict professional guidelines at the Family Institute, P.C. and until, by law, your records are released to be destroyed.
4. Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than that certain data might not otherwise be available to the counselor/therapist to enable him/her to provide you the most effective therapy.