

A Better Way Counseling Center
818 NW 17th Avenue, Suite 8
Portland, Oregon 97209
(503) 226-9061

RELEASE OF INFORMATION

I hereby authorize the staff of A Better Way Counseling Center to release and accept information regarding:

both to and from _____

Phone: (____) _____ for the purpose of treatment coordination.

I specifically authorize the disclosure of information regarding:

- Yes No Family and Living Situation History Yes No Finances
- Yes No Employment/Unemployment Yes No Other: _____
- Yes No Educational Reports _____
- Yes No Alcohol/Drug Treatment _____
- Yes No Mental Health Services _____
- Yes No Medical/Psychiatric Treatment _____
- Yes No Legal History _____

This authorization shall be valid for a period of twelve (12) months from the date signed. I understand that I may revoke this release at any time by submitting a written request, but that such a request will not apply to any information exchanged prior to the date of such a request being received.

Signature _____ Date ___ / ___ / ___

Parent or Guardian _____ Date ___ / ___ / ___

Witness _____ Date ___ / ___ / ___

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

This is a true copy of the original authorization document _____ (Staff Person)