



Release of Information

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

Client Name _____

Birth date _____

I authorize **Legacy Services** or its agents:

- TO RELEASE INFORMATION TO
- TO RECEIVE INFORMATION FROM

<i>Specific Person Agency/Program</i>	<i>Address</i>	<i>Phone- email- fax</i>
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Method: I understand that this contact may take place in person, writing, or by phone, email, fax or other means.

The purpose: To provide the above party information relevant to the assessment and treatment of the client. The signing of this form grants authorization for two way communication: The extent of information to be released includes (please initial on each appropriate line): **Any past and present records, reports, and information regarding:**

- Diagnosis and Treatment Plan
- Progress Notes
- Dates of Services
- Assessments, evaluations, self-reports

Confidentiality: The information will be kept confidential according to statutes, rules, and standards of practice for LPC practitioners (ORS 675, ORS 40.262 Rule 507, OAR 833), child abuse reporting (ORS 419 B), elder abuse (ORS 124), and custody considerations (ORS 107.137). Other rules and laws may apply depending upon the type of record. Information gained will not be re-released without authorization or order.

Length of Authorization: This authorization for release of information will remain in effect until the client has terminated counseling or coaching services with Legacy Services. The client may revoke this consent at any time except to the extent that action has been taken in reliance on it. If the client wishes to cancel this authorization they must do so in writing.

This authorization and release has been explained to me, I understand, and I voluntarily agree.

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____