AUTHORIZATION TO RELEASE AND/OR EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize_____ to
Disclose/Furnish/Receive information and/or records regarding

_____

NAME (Please Print) DOB

To/From: _____

NAME (Inc. Agency/Doctor/Hospital or Program)

Address:_____

Information to be disclosed:

__ Treatment Progress Records and Opinions
__ Medical/Psychiatric Records and Opinions
__ Results of Psychological Testing
__ Educational Records (Including I.E.P.)
__ Discharge Summary
__ Other: _____
_____

This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon. The consent (unless expressly revoked earlier) expires upon: _____

DATE (Event or Condition upon which consent will expire)

SIGNATURE OF CLIENT:_____ DATE: _____

SIGNATURE OF PARENT, GUARDIAN
OR LEGAL REPRESENTATIVE: _____ DATE: _____

SPECIFY RELATIONSHIP: _____ DATE: _____

Please Mail To: Dr. Erroll E. Stephens
10365 SE Sunnyside Suite 315
Clackamas, Oregon 97015
Ph# (503) 855-3051
Fax# (503) 855-3055