

Cornerstone Clinical Services, P.C.

6400 SE Lake Road, Suite 325

Milwaukie, OR 97222

Phone: 503-786-1711 Fax: 503-786-9919

Authorization to Release Information

This document provides the authorization for the release of information and/or the request for information as indicated. Do not sign this release unless it is completed in full and in your best interests. Your refusal to sign this will not affect your ability to obtain health care services or reimbursement for services or enrollment in a health plan unless authorization is required to bill your insurance company, or if the services are solely for the purpose of providing information to someone else, and the authorization is necessary to make that disclosure. It is also understood that if the person that receives your information is not a health care provider or insurer, the information may no longer be protected by federal regulations. You may have a copy of this document if you request.

By **initialing** the spaces below, I, _____ D.O.B. _____
hereby authorize _____, Cornerstone Clinical Services, P.C., to:

_____ release information to: _____ obtain information from: _____ exchange information verbally with:

Contact Person: _____	Agency: _____
Address: _____	City _____ State _____ Zip Code _____
Phone: _____	Fax: _____

_____ For all dates of services
_____ For service between _____ and _____

For the following purposes:
_____ Evaluation, assessment or ongoing coordination of treatment
_____ Other _____

Please initial each line of information to be included:

- | | |
|--|---|
| <input type="checkbox"/> _____ School Records | <input type="checkbox"/> _____ Psychotherapy notes |
| <input type="checkbox"/> _____ Treatment Plan or Summary | <input type="checkbox"/> _____ Psychosocial History |
| <input type="checkbox"/> _____ Psychological Evaluation | <input type="checkbox"/> _____ Test Results |
| <input type="checkbox"/> _____ Chemical Dependency | <input type="checkbox"/> _____ Medical / Hospital / Lab Evaluations |
| <input type="checkbox"/> _____ Diagnoses | <input type="checkbox"/> _____ HIV or AIDS information |
| <input type="checkbox"/> _____ Mental Health Records | <input type="checkbox"/> _____ Other: _____ |

This written consent is subject to revocation in writing at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, this consent shall expire 180 days from signing or _____.

Signature of client, parent or legal guardian

Date signed

Witness

Date signed