Cornerstone Clinical Services, P.C.

6400 SE Lake Road, Suite 325
Milwaukie, OR 97222
Phone: 503-786-1711 Fax: 503-786-9919

7340 SW Hunziker Street, Suite 210
Tigard, OR 97223
Phone (503) 352-0036 Fax (503) 352-0040

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:

____ School Records
____ Treatment Plan or Summary
____ Psychological Evaluation
____ Chemical Dependency
____ Diagnoses
____ Mental Health Records
____ Psychotherapy notes
____ Psychosocial History
____ Test Results
____ Medical / Hospital / Lab Evaluations
____ HIV or AIDS information
____ 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