Sabrina Walters Counseling, LLC
Authorization for Release of Information

Sabrina J Walters, MA, LMFT, LPC
3000 NW Stucki Pl. Suite 230
Hillsboro, OR 97124
Phone: 503-869-8108 Fax: 503-690-0678

I, ____________________________ authorize Sabrina Walters, MA LMFT to release/exchange the

following information to/with _____________________________at _________________________
title(s) agency/organization

Contact info (phone, fax, address) ____

____

Please initial yes or no for each line that applies:

Yes	No	
___	____	Medical Records, Results and/or Recommendations
___	____	Legal History Reports
___	____	Result and/or Recommendations of Evaluation/Assessment
___	____	Treatment Progress Report
___	____	Alcohol/Drug Assessment
___	____	Alcohol/Drug Treatment
___	____	Academic Records/Information re: Attendance, Behavior, Academic Performance
___	____	Other (specify nature of information): Attendance to meetings

Please initial yes or no for each line that applies:

Yes	No	The purpose or need for such release is:
___	____	Facilitate Evaluation/Assessment Process
___	____	Facilitate Treatment Planning
___	____	Coordinate Client Services
___	____	Monitor compliance with Probation Conditions

This authorization shall remain in effect for a period of 180 days (six months) from the date of authorization unless canceled.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described above.

Signature of Client/Participant ___________________________________Date_______________

Signature of Client/Participant ___________________________________Date _______________

Signature of Parent/Guardian/or
Authorized Representative (if required)___________________________Date_______________

Signature of Therapist/Witness ___________________________________Date_______________