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 ________________________________

<table>
<thead>
<tr>
<th>Title(s)</th>
<th>Agency/Organization</th>
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Contact info (phone, fax, address) ________________________________________________________

Please initial yes or no for each line that applies:

<table>
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<tr>
<th>Yes</th>
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| 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:

<table>
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| 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 ______________