



Counseling Services of Portland

Suzie Wolfer LCSW • 503-224-3318

CONSENT TO RELEASE AND OBTAIN INFORMATION

I authorize Suzie Wolfer LCSW to disclose / furnish / receive the following identifying information from the records of:

Name of client _____

Date of birth _____

To / from _____
(name of person, insurance company, agency, doctor, or program)

Address _____

Phone number _____

Extent or nature of information to be disclosed – please initial those that apply

- _____ Medication records and evaluation
- _____ Hospital psychiatric records
- _____ Psychological evaluation
- _____ Diagnosis
- _____ Initial evaluation
- _____ Treatment Plan
- _____ Termination Summary
- _____ Consultation over the phone
- _____ Other _____

This consent to disclose information will expire on: _____

(Date, event or condition upon which consent will expire)

Signature of Client _____ Date _____

Signature of Therapist _____ Date _____