

Cedar Tree Wellness

Kevin Y Riley LCSW, CADC III
636 SW 2nd St. ~ Corvallis, OR 97333 ~Phone: 541-231-7538
Authorization for Release of Information

To our clients: We can help you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.

Client Name: _____ **DOB** _____

Note: If there is more than one professional with whom you would like to communicate, please make a copy of this form for additional names.

I/we hereby authorize Cedar Tree Wellness to share information regarding above mentioned Client with the following professional and the following professional to release information to CTW

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____ E-mail: _____

Relationship to Client: _____

Including Records of: (Client: Please initial next to boxes you check)

Family History	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other, as listed: _____
Educational Reports	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Alcohol/Drug Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mental Health Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Medical/Psychiatric Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

(Alcohol/Drug, Mental Health, and Medical Records include all aspects of diagnosis, treatment, and prognosis. Educational records include both behavioral and progress reports.)

I agree that the agency and/or individual listed above may share and exchange information about my family and my circumstances as checked above. Yes No

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified:

The permission is good for one year, or until: _____

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information as checked above. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

- Parent(s)
- Legal Custody
- Guardian

Client Signature

Date

Signature

Date

Signature

Date