Snapdragon Counseling Services, LLC
Jessica Ferrante LPC, CGAC II, CADC II
3800 SW Cedar Hills Blvd, suite 152-J
Beaverton, OR 97005
(503) 389-3321 Phone
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Release of Confidential Information

This authorization must be written, dated & signed by the client or their representative.

Regarding (Client Name) _____ Birthdate ___/___/____

I will authorize **Jessica Ferrante of Snapdragon Counseling Services** to:
_____ Release information to (and/or) _____ Receive information from

_____
(Person/organization)

_____
(Address)

_____
(Phone Number) (Fax Number)

Information will be used on my behalf for the following purpose(s):
___ Diagnosis & Evaluation ___ Treatment planning
___ Facilitation of ongoing treatment ___ Coordination with other service providers

By Initialing the spaces below, I specifically authorize the release of the following medical / mental health records.

____ Social, medical or psychological reports
____ Treatment goals and results
____ ****Information about drug and/or alcohol abuse**
____ ****HIV/AIDS related records**
____ Other (please specify): _____

This authorization may be revoked at any time, in writing.
Unless revoked earlier, this consent will **EXPIRE 180 DAYS** from the date of signing.

*****This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR, part 2) prohibits you from making any further disclosure or it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal regulation also restricts any use of the information to criminally investigate or prosecute the patient.***

_____ _____
Client or Legal Guardian Signature Date

_____ _____
Jessica Ferrante LPC, CGAC II, CADC II Date