***Anita Abelsen-Gay, MA, LPC***

*CenterPointe Therapists, LLC*

*6901 SE Lake Road, Suite 27*

Milwaukie, OR 97267

*Phone (503)358-6743 FAX (503)387-3757*

Consent for Release of Confidential Information

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , hereby authorize and request

 (Client’s Name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Outside Practitioner’s Name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Address) (Phone)

 to release all pertinent confidential professional information pertaining to me (or my

child) to Anita Abelsen-Gay, MA, LPC \_\_\_\_\_ (client's initials)

 I authorize and request that Anita Abelsen-Gay, MA, LPC share all pertinent and confidential professional information with the above named practitioner. \_\_\_\_\_ (client's initials)

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing in writing any of the above noted individuals. I further understand that this authorization is valid only for a period of one year from the date of my signature below.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Client)

OR

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Parent, Guardian, or Legal Representative)