Sundstrom
CLINICAL SERVICES

8440 SE Sunnybrook Blvd., Clackamas, OR. 97015 •Phone: (503) 653-0631• Fax: (503) 653-1464

Authorization To Release Information

This document provides the authorization for the release of information and/or the request for information as indicated below. Do not sign this release unless it is completed in full and in your best interests. It is also understood that if the person or organization that receives your information is not a health care provider or health insurer, the information may no longer be protected by federal regulations. You may inspect and/or have a copy of this authorization and the information being released if you request one.

_____	_____	_____
Client Name	Date of Birth	Social Security #

I, the undersigned, hereby authorize _____ and Sundstrom Clinical Services, LLC to receive information from and/or send information to:

Contact Person/Agency: _____

Address: _____

_____

Phone #: ( )_____ Fax #: ( )_____

This authorization for release extends to the care and treatment the client received during:

- ☐ All dates of service
- ☐ Service between _____ and _____

This information may be used for the following purpose (s):

- ☐ Evaluation, assessment and/or treatment
- ☐ Ongoing coordination of treatment
- ☐ Other _____

Please **initial** the information to be released:

_____ School Transcripts/Records
_____ Treatment Plan or Summary
_____ Psychological Evaluation/reports
_____ Chemical Dependency Information
_____ Diagnoses
_____ Mental Health Treatment
_____ Test Results
_____ Hospital Discharge Summary
_____ Medical Evaluations
_____ Lab/ X-ray/ Pathology
_____ HIV or AIDS information
_____ Psychosocial History
_____ Other: _____

This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier, revoked, or by other agreement specified below, this consent shall expire:

_____ Six months from the date signed
_____ One year from date signed
_____ Therapy Termination
_____ Other

_____	_____
Signature of client, parent or legal guardian	Date signed