

CONSENT FOR EXCHANGE OF INFORMATION

Regarding Whom: _____

What Information: _____

For What Purpose: _____

Between:

Clifford A. Johannsen, Ph.D.
P.O. Box 2004
Lake Oswego, Oregon 97035

Phone: 503-246-5986
Facsimile: 503-635-0583
e-mail: cjohannsen@comcast.net

And:

_____			_____	
Name			Phone	
_____			_____	
Street			Facsimile	
_____			_____	
City	State	Zip	E-mail	

You are hereby authorized to exchange both written and verbal information pertaining to me and my record. You are released from all liability that might arise from the exchange of this information.

I acknowledge that information to be released may include material concerning drug or alcohol abuse and mental health treatment that is protected by Federal Law. My signature below authorizes release of such information between the persons or agency named above.

This authorization shall continue in effect until one year from the date signed. Consent to release information may be revoked in writing at anytime, except to the extent that action authorized by the release has already taken place. A photo copy of this release shall have the same validity as the original.

Signed:

_____			_____	
Patient			Date	
_____			_____	
Parent or Guardian			Date	

Witness				