CONSENT FOR RELEASE OF INFORMATION

From:

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

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Facsimile (503) 635-0583
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To:

_____ Phone: _____
Name

_____ Facsimile: _____
Street

_____ E-Mail: _____
City State Zip

Patient Name:

What Information:

For What Purpose:

Dr. Johannsen is hereby authorized to provide the above confidential verbal or written information pertaining to

☐ me ☐ my child

and he is released from all liability that might arise from the delivery of this information to the person or agency named above.

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 Dr. Johannsen to release such information to the person 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.

_____ _____
Client Signature Date

_____ _____
Parent or Guardian Signature Date

_____
Witness Signature