Barbara Lauer, LCSW

Release of Information

CLIENT

Client Name

Date of Birth

AUTHORIZATION

I hereby authorize:

Name, agency, and contact information

To exchange information with:

Barbara Lauer, LCSW
1829 NE Alberta St., #5
Portland, OR 97211
503-715-1962
833-841-3305 fax

REASON FOR THIS AUTHORIZATION

- ☐ Continuity of care — exchange between providers
- ☐ Release of records
- ☐ Other

INFORMATION TO BE DISCLOSED

- ☐ Information may be exchanged verbally or in writing
- ☐ Written records may be exchanged
- ☐ Other

I UNDERSTAND THE FOLLOWING

1. This release expires one year from the date of my signature below, or on (date).
2. I can revoke this authorization at any time in writing.
3. This release does not impact my relationship or treatment with Barbara Lauer.
4. There is no fee associated with this release.
5. I am entitled to a copy of this release.
6. I can refuse to sign this authorization.

SIGNATURES

Please complete and return this form to your provider.

Client Signature

Date

Parent / Guardian Signature

Date