Brian H. Farr, MA, LPC
818 NW 17th Ave, Suite 10
Portland OR 97209 503-887-7498

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, the undersigned client, born on ____/____/____, authorize Brian H. Farr, LPC to communicate with and receive communication from the following individual or institution:

Name: _____

Address: _____

_____

Phone: _____

INFORMATION TO BE DISCLOSED (**please initial**):

_____ Attendance

_____ Assessment and treatment plan

_____ Evaluation and progress in treatment

_____ Information relevant to couples/family counseling

_____ Other: _____

The purpose of this disclosure is to coordinate communication with the above-mentioned person or institution. I understand this release is valid until 90 days following the termination of services with Brian H. Farr, LPC. I understand that disclosures are bound by rules governing confidentiality and that information cannot be disclosed without my written consent except in cases of specific homicidal or suicidal threats and physical, sexual or financial abuse of a minor child, the handicapped or the elderly.

Client Signature: _____ Date: _____

Witness: _____ Date: _____