ALLIES IN CHANGE
1675 SW MARLOW, SUITE 110
PORTLAND, OR 97225
(503) 297-7979
(503) 297-7980 (Fax)

RELEASE OF CONFIDENTIAL INFORMATION

I, _____ (Date of birth:____/____/____), hereby authorize the staff of Allies in Change to release information to and accept information from:

Person/Agency_____ Phone_____

Address_____ Fax_____

For the purpose of treatment coordination, I specifically authorize the disclosure of information regarding :

Client initials:

____yes ____no Mental health services

____yes ____no Progress reports

____yes ____no Enrollment/discharge reports

____yes ____no Medical treatment

____yes ____no Alcohol/drug treatment

____yes ____no Entire mental health record

____yes ____no UA results

____yes ____no Other: _____

I understand that: a) I can revoke this release at any time by submitting a written request, but such a request will not apply to any information exchanged prior to the date of such request; b) if I revoke this release, the agency may not be able to provide services to me; and c) that some exceptions to confidentiality exist and have been explained to me.

This authorization expires one year from the date signed or 30 days following termination of services, whichever comes first.

Client signature_____ Date_____

Witness signature_____ Date_____