Teresa R. Weis, LPC, LMFT
Insights Outside, LLC
3719 N. Williams Ave.
Portland, OR 97227

Phone: 503.730.8903
Fax: 503.285.4022

Authorization to Release/Receive Confidential Information

Client Name _____ **Birth Date** _____

I authorize Teresa Weis to:

(Please initial all that apply)

___ **receive information from:**
___ **release information to:**

Person and/or Agency _____

Address _____

City, State, Zip Code _____

Phone number _____ **Fax number** _____

This information is needed for the following purpose(s): (please initial all that apply)

___ **Mental health treatment, planning, consultation and continuity of care**

___ **Diagnosis and assessment**

___ **Other** _____

The information to be disclosed includes the following: (please initial all that apply)

___ **Information about past/current treatment**
___ **Assessment/Testing**
___ **Consultation**
___ **Physical health/medical information**
___ **Treatment Summary**
___ **Medications in Treatment**
___ **Treatment goals, progress and results**
___ **Alcohol and Drug Treatment Information**
___ **AIDS/HIV**
___ **Other**

I understand that my records are protected under the federal HIPPA and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that Teresa Weis MA, MFT cannot guarantee that the recipients of this information will not re-disclose my health information to another party. I also understand that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on it.

This authorization shall remain in effect until _____ **or until 30 days after termination of counseling services with Teresa Weis, LPC, LMFT.**

Client Name _____ **Date** _____

_____

Parent/Guardian/Legal Representative (required if client is under 18 or not competent to sign) **Date**

Witness Signature _____ **Date** _____