Mira Shah Art Therapy & Counseling
12525 SW 3rd Ave.
Beaverton OR 97005
(503) 367-3268
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RELEASE OF CONFIDENTIAL INFORMATION

I, ________________________________ (Date of birth: ____/____/_____), hereby authorize Mira Shah, LPC 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 - 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 exchange 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/Parent signature _____________________________ Date _______________

Therapist signature _________________________________ Date_______________