Amanda P. Orton, LMFT
Licensed Marriage & Family Therapist
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541-393-9008

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name_____Date of Birth:_____

I, _____authorize communication between

Amanda P. Orton, LMFT and _____
_____

This communication may include official reports and a pertinent summary of the client's psychological and psychiatric history, including current condition, participation and progress in treatment and recommendations. The purpose of such communication is:

_____the coordination of services

_____ _____

I agree that a photocopy of this signed authorization shall be as valid as the original. This consent is subject to revocation by the undersigned at any tine except to the extent that action has been taken in reliance thereon. If not earlier revoked, this consent terminates on _____.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Parent, Conservator or Guardian Date