CHRISTOPHER G. MARQUARDT, M.S., M.A.T., NCC
Registered LPC Intern *under supervision of Tever D. Nickerson, LPC*

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize Christopher G. Marquardt, LPC (Registered Intern) to use and disclose the specific protected health information described below regarding:

_____ DOB: _____

as is necessary to: ___ release information to, and/or ___ receive information from:

_____ (Person/Organization)

_____

Address City/ State (Phone/Email/Fax)

The information to be shared or disclosed includes:	**YES**	**NO**
Social, medical or psychological reports.		
Medications used in treatment.		
Treatment goals and results.		
Information about drug and/or alcohol abuse or treatment.		
Court or probation records.		
Other:		
The information disclosed will be utilized for the following purpose(s):	**YES**	**NO**
Diagnosis and evaluation.		
Treatment planning.		
To facilitate treatment.		
Other:		

If we are requesting this Authorization from you for our own use and disclosure, or to allow another health care professional or health care entity to disclose information to us: (1) We cannot deny our services or treatment to you if you refuse to make this signed authorization; (2) You have the right to inspect a copy of the protected health information to be used or disclosed; (3) You may refuse to sign this Authorization; and (4) We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this **Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.**

By signing this Authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners by their ethical codes and under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

_____ (initial) I understand that alcohol and/or drug treatment records are protected under federal and state regulations (42 CFR Part 2 and ORS 430.399(5), 179.505) governing Confidentiality of Alcohol and Drug Abuse Patient Records, and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows: _____- _____

(Specify the date, event, or condition upon which the Authorization expires)

I have reviewed this Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and may no longer be protected.

_____ _____

Client Name, Signature & Date ***Client Name, Signature & Date***

2304 E. BURNSIDE, SUITE 3 PORTLAND OR, 97214
PHONE: 971.270.0792 christopher@cgmcounseling.com FAX: 413.618.1099
www.cgmcounseling.com