Lisa M. Loewenthal, LCSW 503-896-4499
1020 SW Taylor, Suite 660, Portland, OR 97205

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Client Name: _____ D.O.B.:_____

I specifically authorize Lisa M. Loewenthal, LCSW to (initial) _____ obtain information from and/or (initial)_____ provide information to:

Name: _____ Address:_____
Phone: _____ Fax: _____

By initialing below, I authorize the information to be used on my behalf for the following purposes:
_____Treatment planning _____Coordination of care _____Other as specified _____

By initialing below, I authorize release of the following medical records if such records exist:
_____ Clinical office chart notes
_____ Intake summary and treatment plans
_____ Billing statements
_____ Medical records needed for continuity of care
_____Other _____
_____ HIV/AIDS related records*
*Must be initialed to be included in other documents
_____ Mental health information
_____ Drug/alcohol treatment and referral information**
**Federal regulation 42RF Part 2, requires a description of how much and what kind of information is to be disclosed.

_____This authorization is limited to the following treatment: mental health treatment
_____This authorization is limited to the following time period: duration of treatment
_____ This authorization is limited to worker's compensation claim for injuries of _____ (date)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire in one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of client or personal authorized by law

_____

Date _____