Randi Weber Thoma, LPC, CCMHC
5410 SW Macadam Ave., Suite 255
Portland, OR 97239
503.684.7948
503.684.7958 (Fax)

Release of Information

Authorization of Disclosure of Records

I hereby authorize Randi Weber Thoma, LPC to disclose/receive the following information to/from the records of:

Name: _____ Date of birth: _____

To/From: _____

Phone: _____ Address: _____
_____

I specifically authorize the release of the following:

Please check information to be disclosed:

- ☐ Drug and Alcohol Treatment Records
- ☐ Psychiatric/Mental Health Treatment
- ☐ Treatment Plans
- ☐ Progress in Treatment
- ☐ School Records
- ☐ Assessment and Diagnosis
- ☐ Evaluations
- ☐ Entire Health Record
- ☐ Scheduling
- ☐ Other- Specifically _____
  _____

The above information will be used for the following purposes: diagnosis and treatment, coordination of mental health and medical care, administration of health care service plans, and/or _____
_____

I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions, as well as other health conditions and information. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it. This consent is effective for one (1) year from the date it is signed unless otherwise specified as follows: _____

Signature of client: _____ Date: _____

Signature of parent or guardian: _____ Date: _____

Signature of witness: _____ Date: _____