Pillars of Hope Counseling, LLC
6950 SW Hampton Street, #311
Tigard, OR. 97223
(503) 841-2142

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Pillars of Hope Counseling by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Angelie Karabatsos LPC, NCC with Pillars of Hope Counseling to:

☐ Release Records: ☐ Obtain Records: ☐ Exchange With: ☐ Other:

The following information pertaining to myself:

☐ Treatment summary ☐ History/Intake ☐ Diagnosis ☐ Psychological test results

☐ Dates of Treatment ☐ Specific Letter ☐ Scheduling on behalf of client

☐ Other (specify) _____

To or From:

_____

_____

_____

For the Purpose of:

☐ Evaluation/Assessment

☐ Coordinating Treatment Efforts

☐ Other _____

I understand this is a one-time authorization and if other requests are made additional authorizations are required. I understand once the requested information is provided, the person/s, or organization may not be bound by confidentiality or HIPPA regulations and may disclose the above information to others. I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

X_____ _____
Signature of Client Date

X_____ _____
Signature of Client Date