

RELEASE OF INFORMATION

This form grants me permission to consult with another professional about your child's mental health and behavior. Their observations will allow me to better plan counseling sessions and meet our counseling goals.

Client Name

Date of Birth

I authorize Nick DeMayo, LMFT to consult with the professional listed below on matters pertaining to the mental health of my child.

Release information to/from:

Release information to/from:

Nick DeMayo, LMFT
2926 NE Flanders St. #2A
Portland, OR 97232
(503) 354-7100

Name: _____

Address: _____

Phone: _____

Specific information to be shared may include:

- Mental health record
- Summary of treatment
- Assessments and evaluations
- Psychosocial history

I acknowledge that I may revoke this authorization in writing at any time.

This authorization will expire upon termination of counseling sessions.

Parent Signature

Date