Nick DeMayo, LMFT
www.counselorforteens.com

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:

Nick DeMayo, LMFT
2929 SW Multnomah Blvd. Ste 304
Portland, OR 97219
(503) 354-7100

Release information to/from:

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