David E. Blakeslee, Psy.D., P.C.
4000 Kruse Way Pl., Bldg. 2-200
Lake Oswego, OR 97035
Phone: 503-699-8389 Fax: 503-635-5414

AUTHORIZATION TO RELEASE INFORMATION

PATIENT NAME: ____

BIRTHDATE: ___________________________ SSN: ____________________

I/WE HEREBY AUTHORIZE: ______________________________________
NAME/INSTITUTION

____
STREET ADDRESS CITY/STATE/ZIP

____
AREA CODE AND PHONE NUMBER FAX

AND DAVID E. BLAKESLEE, PSY.D., P.C. to exchange any information, medical, psychological, scholastic, social which may pertain to my/our child ________________________________ or myself. The question of privacy between the above named parties and the patient is waived. This authority extends to the furnishing of copies of all or any desired parts of the records pertaining to the above mentioned person or persons. **I specifically authorize the release of information pertaining to psychological and/or psychiatric impairments, drug and/or alcohol abuse, if such is a part of my records.** You are hereby released from all legal liability that may arise from the release of the information requested.

DATA REQUESTED:

_____ HISTORY AND PHYSICAL
_____ DISCHARGE SUMMARY
_____ MEDICATION MANAGEMENT
_____ PROGRESS NOTES
_____ PSYCHOLOGICAL TEST RESULTS
_____ CONSULTATION
_____ TREATMENT SUMMARY
_____ OTHER___________________________

This release expires 12 months from the date of signature. It may be revoked with written notification at any time except to the extent that action has been taken in reliance on the consent.

______________________________ ______________________________
Signature of Patient Signature of Parent/Guardian

______________________________ ______________________________
Date Signature of Parent/Guardian

____
Witness