



AUTHORIZATION FOR RELEASE OF INFORMATION

Catherine Freer Wilderness Therapy Programs
PO Box 1064, Albany, OR 97321
541-926-7252/phone • 541-812-0116/fax

We can better ascertain if your child would be an appropriate candidate for our program if we are able to speak with mental health professionals and/or other agencies that are working on behalf of your child. By signing this form, you are giving permission for these individuals and/or organizations to share information about your situation.

Parent (s) Name: _____ Applicant's Name: _____

Applicant's DOB : _____

I/we hereby authorize CFWTP to release information regarding above mentioned Applicant to the following professional and the following professional to release information to CFWTP. (Note: If there is more than one professional with whom you would like to communicate, please make a copy of this form for additional names.):

Name: _____ Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____) _____ Fax: (____) _____ E-mail: _____
Relationship to Client: _____

Please check all that apply:
 Discuss specifics of child's clinical and behavioral issues for enrollment screening.

Including Records of: (Client: Please initial next to boxes you check)

- | | | |
|-------------------------------|--|--|
| Family History | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Other, as listed: _____ |
| Educational Reports | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Alcohol/Drug Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Mental Health Services | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Medical/Psychiatric Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

(Alcohol/Drug, Mental Health, and Medical Records include all aspects of diagnosis, treatment, and prognosis. Educational records include both behavioral and progress reports.)

I agree that the agency and/or individual listed above may share and exchange information about my family and my circumstances as checked above. Yes No

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified. The permission is good for one year, or until: _____

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information as checked above. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

<input type="checkbox"/> Parent(s)	_____	_____
<input type="checkbox"/> Legal Custody	Signature	Date
<input type="checkbox"/> Guardian	_____	_____
	Signature	Date