

Brian H. Farr, MA, LPC  
1020 SW Taylor Street, Suite 820  
Portland, OR 97205  
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**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, the undersigned client,  
born on \_\_\_/\_\_\_/\_\_\_, authorize Brian H. Farr, LPC to communicate with  
and receive communication from the following individual or institution:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**INFORMATION TO BE DISCLOSED (please initial):**

- \_\_\_\_\_ Attendance
- \_\_\_\_\_ Assessment and treatment plan
- \_\_\_\_\_ Evaluation and progress in treatment
- \_\_\_\_\_ Information relevant to couples/family counseling
- \_\_\_\_\_ Other: \_\_\_\_\_

The purpose of this disclosure is to coordinate communication with the above-mentioned person or institution. I understand this release is valid until 90 days following the termination of services with Brian H. Farr, LPC. I understand that disclosures are bound by rules governing confidentiality and that information cannot be disclosed without my written consent except in cases of specific homicidal or suicidal threats and physical, sexual or financial abuse of a minor child, the handicapped or the elderly.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_