Adam J. Rodríguez, Psy.D.
1020 SW Taylor Street, Suite 650 • Portland, OR 97205
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(503) 308-9770

CONSENT TO RELEASE INFORMATION

Patient's Name: ______________________________ Date of Birth: ___________________________

Guardian (if minor): ___________________________ Patient's Social Security #: ________________

I request and authorize **ADAM J. RODRÍGUEZ, PSY.D.** to release healthcare information of the patient named above to:

Name and/or Organization: ____

Phone #: ________________________ Email: _________________________________

Address: ____

City, State, and Zip Code: ____

This request and authorization applies to:

- ☐ My attendance in therapy
- ☐ My diagnosis
- ☐ My treatment plan
- ☐ Information relevant to coordinating care
- ☐ Other: ____

I understand that: 1) this authorization is voluntary; 2) the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected; 3) I am entitled to a copy of this authorization, should I request one; 4) this authorization will expire 6 months from the original authorization date; 5) I have the right to revoke this authorization at any time, by written notification only, except to the extent that the information has already been disclosed.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

Patient or Guardian's Signature: _________________________ Date: _____________________