JENNIFER D. SAMSOM, M.A.
MINDFUL • EXPERIENTIAL • SOMATIC THERAPY FOR COUPLES • FAMILIES • INDIVIDUALS

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, give my permission to Jennifer D. Samsom, M.A.
(Name of client)
to release/obtain information in the form of written records and/or verbal consultation with/to/from:

_____

about my self/child: _____
(Client's or child's full name)

to/from: _____
(Name of organization or person receiving or providing records)

I understand that this information will be used only for the purpose of: _____

_____
(Purpose for which records and/or information will be used)

The authorization will be in effect from _____ until _____, or for one year unless otherwise rescinded.

I understand that I give my permission for the records and/or information to be obtained from or released to only the person or organization, and for the purpose listed above, and only for the time shown above. I may withdraw my consent at any time in writing, or, if I am physically unable to write, by orally advising Jennifer D. Samsom, M.A.

_____	_____
Jennifer D. Samsom, M.A.	Signature of Client or Parent/Guardian of Child under 16 years of age
Date: _____	Date: _____

IF CLIENT(S) IS/ARE UNABLE TO SIGN:

We affirm that _____ was/were physically unable to sign this
(Name of client(s))
authorization, but that he/she/they give(s) his/her/their verbal consent to obtaining or releasing the foregoing records and/or information and understand(s) the nature of this authorization.

_____ Date: _____
Witness Signature

15 SE 16TH AVENUE • PORTLAND • OREGON 97214
JENN@MINDFULTHERAPYPORTLAND.COM • (503) 341-6393 • WWW.MINDFULTHERAPYPORTLAND.COM