

REHABILITATION CONSULTANTS, INC.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Rehabilitation Consultants to contact and exchange information with:

1. _____
AGENCY/PERSON

2. _____
AGENCY/PERSON

ADDRESS

ADDRESS

3. _____
AGENCY/PERSON

4. _____
AGENCY/PERSON

ADDRESS

ADDRESS

Regarding the following individual:

NAME: _____ DOB: _____

AKA: _____ PARENT\GAURDIAN: _____

Kind of information: (check one or more)

Social Medical Psychological
 Vocational Educational Other _____

This information will be used for case planning purposes in the efforts to find employment for the individual.

This authorization is in effect

FROM _____ TO _____
DATE DATE

(This form is invalid if the above line is not filled out)

It is my understanding that all information received by Rehabilitation Consultants as a result of this authorization will be treated as confidential.

CLIENT DATE

ADDRESS

PARENT\GAURDIAN DATE

WITNESS DATE