Registration and Release of Information

Full Name DOB

Home Address

Email Address

Cell and Work Phone #

Emergency Contact

Phone#

Employment ☐ F/T ☐ P/T ☐ Student ☐ P/T Student ☐ Other

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Roommate

Name person responsible for payment

Email Address

I hereby authorize Sue Colavito, MA LPC to exchange confidential information with the following professionals. Information will be used for assessment and treatment planning.

Primary Care Physician and Phone#

School Name and Phone#

Teacher

Counselor

Other Therapist or MD and phone#

I have read and understand Sue Colavito's **policy** letter regarding confidentiality. This authorization will remain in effect for one year unless withdrawn in writing.

Signature of Client or ResponsibleParty:

Relationship to Client: Date

Sue Colavito
1759 NW Meadows Drive
McMinnville OR 97128
www.suecolavitoma.com suecolavito1@gmail.com
503-7446675