A New Life Is Possible One Step at a Time
www.anlcc.com

Brad L. Peterson, Program Supervisor
Greg Goostree, Program Staff
WA State Certified Domestic Violence
Perpetrator Treatment Program
201 NE Park Plaza Drive Suite 293 L
Vancouver, WA 98684
Phone: (360) 773-4715
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Release of Information
Victim

I, ______________________________________ Date of Birth _____________
(Client's first and last name)

dated ________________, 20_____ authorize information to be exchanged between the following person and A New Life Christian Counseling and/or Brad L. Peterson, MA for the purpose of treatment coordination as stated below.

Name of Victim(s):________________________________ Relationship:___________________

Address/City, State: ____

Zip Code: ___________________ Phone: _____________________ Work: ________________

This request and authorization applies to:

Information in accordance with WAC 338-60 requires that state certified treatment programs notify the victim, the victim's community advocates and legal advocates with certain information that includes entry into treatment, termination from the treatment program, and any other information related to victim safety.

Other: ____

____
Signature of Client   Date Signed

____
Signature of Witness   Date Signed

A New Life
Christian Counseling

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Portland Office Location:
Eastside Foursquare Ministry Campus
9727 NE Sandy Blvd., Suite 374
Portland, OR 97220
Brad Peterson: (503) 753-4440
Jay McCall: (503) 548-7737
Robyn Honeycutt: (503) 545-7846
Office Fax: (503) 296-2071

Vancouver Office Location:
Park Tower Addition
201 NE Park Plaza Dr., Suite 293-L
Vancouver, WA 98684
Brad Peterson: (360) 980-7906
Greg Goostree: (360) 773-4715
Sara Pirolo: (360) 980-4436
Office Fax: (360) 326-1859

Parental Consent to Counseling

I, ____________________________, give consent to have my daughter/son ____________________________
(Printed name of parent or guardian) (Printed name of client)
enter into counseling with ____________________________ at A New Life Christian Counseling.
(Printed name of counselor)

I understand that the communication between my daughter/son and their counselor is confidential, and that confidentiality will be broken only in the case of them being a danger to themselves or to others, or if otherwise required by law. Therefore, I fully understand that even I as a parent will not be provided with any information regarding communication between my daughter/son and their counselor, unless specific permission for certain information is given by my daughter/son by their initials below:

____ Yes ____ No Counseling Progress/Treatment Goals/Prognosis

____ Yes ____ No Evaluation/Assessment Results & Recommendation(s)

____ Yes ____ No Alcohol/Drug Treatment/Counseling History

____ Yes ____ No Mental Health Services/Counseling History

____ Yes ____ No Medical/Psychiatric Treatment History

____ Yes ____ No Financial Payment Arrangement(s)

____ Yes ____ No Other ______________________________

____ Yes ____ No Other ______________________________

I have had the opportunity to fully discuss with said counselor the risks and benefits of treatment, as well as treatment choices and methods. I have had all my questions answered and I understand and approve the treatment that is planned.

Under penalty of law, I hereby declare that I am the parent of this child. Parent means a biological or adoptive parent having legal custody of the child or a person or agency judicially appointed as legal guardian of the child.

Dated ________________, 20___

Signature of Parent or Guardian: ______________________________

Signature of Parent or Guardian: ______________________________

Signature of Counselor : ______________________________