OREGON BOARD OF LICENSED PROFESSIONAL COUNSELORS & THERAPISTS
CUSTODIAN OF RECORD
DESIGNATION FORM

Your Name: _____________________________________ License/Registration # ______________

I designate one of the following as the custodian of my clients’ records:

A licensed health or mental health care individual
A records management company
An attorney
A health care organization
A mental health care organization
A school

____________________________________________________________________________
Name of designated custodian

Address: ____________________________________________________________________

Phone number: ______________________   Email: __________________________________

____________________________________________        ____________________________
Signature of Custodian of Record (if appropriate)    Date

I understand that I must promptly inform the Board of any change to this custodian of record. I
swear/affirm that the information provided above is accurate.

_____________________________________________      ____________________________
Signature (required)         Date (required)

Please return the completed and signed form to the Board office. If you need to change your
designation for the Custodian of Record, the form can be downloaded from the Board’s website
at www.oregon.gov/oblpct. You may send the form by mail, facsimile, or as an attachment to
an email message to:

Oregon Board of Licensed
Professional Counselors & Therapists
3218 Pringle Road SE Suite 120
Salem, OR 97302-6312

Fax: 503-373-1427
Email: lpct.board@state.or.us

October, 2012