cohncounseling

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize_____ to use and disclose the specific protected health information described below_____
Regarding: _____ Date of Birth:_____
as is necessary to: ___ release information to, and/or ___ receive information from:

_____

_____
address city/ state (phone)

The information to be used or disclosed includes:
____ Social, medical or psychological reports.
____ Medications used in treatment.
____ Treatment goals and results.
____ Information about drug and/or alcohol abuse or treatment
____ Court or probation records
Other:

This information disclosure is necessary for the following purpose(s):
___ Diagnosis and evaluation.
___ Treatment planning.
___ To facilitate treatment.
Other:

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care professional or health care entity to disclose information to us: (1) We cannot deny our services or treatment to you if you refuse to make this signed authorization; (2) You have the right to inspect a copy of the protected health information to be used or disclosed; (3) You may refuse to sign this Authorization; and (4) We must provide you with a copy of the signed authorization. You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. **Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.**

By signing this Authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners, health plans and other health care entities observe under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure

of your protected health information and loss of protection under state and federal law. You may request that we require the recipient of your protected health information to sign a **Confidentiality Agreement** in which the recipient agrees to limit its use and disclosure of your information as specified by the **Confidentiality Agreement**. If the intended recipient refuses to sign the confidentiality agreement you request, we will not release the information.

_____ **(Your Initials**) I request that the recipient of the information identified above for disclosure sign a Confidentiality Agreement.

_____ **(Your Initials)** I understand that my alcohol and/or drug treatment records are protected under federal and state regulations (42 CFR Part 2 and ORS 430.399(5), 179.505) governing Confidentiality of Alcohol and Drug Abuse Patient Records, and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in an event this authorization expires automatically as follows:
_____ (Specify the date, event, or condition upon which the Authorization expires)

I have reviewed this Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law.

_____ _____
Client Signature Date

_____ _____
patient (or) legal representative Date
& legal representative's authority