Counseling Services of Portland

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Authorization to Release and Exchange Information

I, _____, _____ give permission to the
Client Name Birth date

Counseling Services of Portland and its staff to disclose and obtain mental health treatment information and records obtained in the course of my psychotherapy treatment, including, but not limited to, my therapist's diagnosis to:

_____ _____
Your physician or psychiatrists name Phone number

Information to be Disclosed: _____ Entire mental health and/or substance abuse record,
Initial

or such disclosure shall be **limited to the following specific types of information**: (client must initial each item to be released):

Initial		Initial	
___	Substance abuse evaluation	___	Treatment recommendations
___	Expected length of treatment	___	Attendance records only
___	Diagnosis/assessment	___	Treatment plan
___	Name of new treatment provider	___	Treatment progress report
___	Medication information	___	Other (specify) _____

Purpose for Disclosure (client must initial):

Initial
___ Continuity of care
___ Care management and processing of benefit claims
___ Education coordination
___ Coordination and collaboration of care
___ Other (specify) _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the **right to revoke** this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such **revocation must be in writing and received by Provider at address listed above** to be effective. Therapist shall **not condition treatment upon Client signing this authorization.** I have the **right to refuse to sign** this form. I understand that information used or disclosed in this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Oregon law may protect such information.

This authorization shall remain valid until one year after termination of treatment or _____

_____ _____
Client signature Date

_____ _____
Signature of parent, guardian, conservator or authorized rep. Date

_____ _____
Therapist as Witness Date

Notice to Recipient of Information

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFE Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse member.