AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

For the Behavioral Health Department of The Corvallis Clinic, P.C., 444 NW Elks Drive, Corvallis OR 97330

AUTHORIZATION

I hereby authorize Dr. _____, of THE CORVALLIS CLINIC, P.C. to use and disclose the specific protected health information described below, regarding:

PATIENT NAME _____ **DATE OF BIRTH** _____

As is necessary to: *(Check one or both)*
- ☐ Release information to:
- ☐ Receive information from:

Purpose for Release: *(Check one)*
- ☐ Coordination of care
- ☐ Change of provider
- ☐ Self
- ☐ Assist Evaluation
- ☐ Other_____
- ☐ Scheduling

_____

Recipient (person or organization that will receive or release your information)

_____

Street Address **City** **State** **Zip**

INFORMATION TO BE RELEASED *Initial each category of information to be released. Those **not** initialed will **not** be released.*

Mental Health Information, including diagnosis and treatment	_____ ←
Drug and/or alcohol use, or treatment information	_____ ←
Medical records including diagnoses, treatment & medications	_____ ←
School transcripts, educational testing and behavioral records	_____ ←
Psychological testing	_____ ←
Other: _____	_____ ←

Initials required for each category to be released

I understand that any alcohol and/or drug treatment records are protected under federal and state regulations, governing Confidentiality of Alcohol and Drug Abuse Patient Records, and cannot be disclosed without my signed authorization above unless otherwise provided for in the regulations.

PLEASE BE ADVISED

1. **You may refuse to sign this authorization;**
2. **We cannot deny our services or treatment to you if you refuse to make this signed authorization;**
3. **You have the right to inspect a copy of the protected health information to be used or disclosed;**
4. **We must provide you with a copy of the signed authorization; and**
5. **Once information is disclosed, it may be re-disclosed by the recipient without the knowledge or consent of The Corvallis Clinic or you, and may not be protected by Federal privacy regulations.**

READ AND UNDERSTOOD _____ **Initials Required**

REVOCATION and EXPIRATION

You may revoke this Authorization at any time by submitting your request in writing to the attention of the Patient Advocate of The Corvallis Clinic, P.C., 444 NW Elks Drive, Corvallis, Oregon, 97330, (541) 758-2730, and except to the extent that we have used or disclosed information. ***Unless revoked earlier or otherwise indicated below, this Authorization will expire 1 year from the date of signing.*** **Specify date or event that this authorization expires:** _____

READ AND UNDERSTOOD _____ **Initials Required**

FAX TRANSMITTALS

I understand that all faxed information will contain a confidentiality statement and instructions for returning misdirected information. I also understand that confidentiality cannot be guaranteed on the receiving end of a fax transmittal. I specifically give authorization to FAX my Behavioral Health information.

READ AND UNDERSTOOD _____ **Initials Required**

I HAVE REVIEWED THIS AUTHORIZATION AND UNDERSTAND IT OR HAVE REQUESTED FURTHER EXPLANATION AND AM SATISFIED WITH THE EXPLANATION PROVIDED.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Description of Personal Representative (i.e. Parent, Guardian, Power of Attorney)