**Authorization to Release and Exchange Information**

I, (Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (Birthdate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission to Grace Abounds Counseling, LLC 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 psychiatrist’s name or educational institution Phone number

Information to be Disclosed:

(Initial) \_\_\_\_\_ Entire mental health and/or substance abuse record, **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.