Oregon Mental Health Services, LLC

Authorization to Release, Obtain, and/or Exchange Information

CLIENT:

_____ _____
(Name of client) (D.O.B.)

_____
(Street Address)

_____
(City, State, Zip Code)

I HEARBY AUTHORIZE:

_____
(Name of Provider)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Phone number)

To ☐ **obtain from** ☐ **release to** and/or ☐ **exchange** health information and school records with Oregon Mental Health, LLC, 165 W. Netherwood St. Oregon, WI 53575

Description of Information to be Disclosed: (Patient/Client should **initial** each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan, Update or Summary
_____ Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Verbal Information
_____ Demographic Information
_____ Presence/Participation in Treatment
_____Other_____

Purpose of Release: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Expiration: Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated: _____.

Notices:

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Oregon Mental Health Services, LLC at 165 W Netherwood St. Oregon, WI 53575. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Conditions: I further understand that Oregon Mental Health Services, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to verbally, in paper format, or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections.

_____ _____
Client Signature or Person Authorized to Consent Date

_____ _____
Signers Name (if signed by representative rather than client) Signer's Authority

(If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____ Check here if patient/client refuses to sign authorization

_____
Signature of staff witness Date