**AUTHORIZATION TO COMMUNICATE PROTECTED HEALTH INFORMATION**

Your signature on this form will authorize PDX Mental Health Resources, LLC to receive and/or disclose private information about you. Health information is protected by federal and state law and by PDX Mental Health Resources, LLC policy. Do not sign this form unless it is **completed in full** and in your best interest.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Client Name: | | Social Security #: | | |
| Date of Birth: | | | | |
| Address: | City: | | State: | Zip Code: |

With my signature below, authorize PDX Mental Health Resources LLC, to receive/disclose information to:

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Person: | | | |
| Address: | City: | State: | Zip Code: |
| Phone: (     )     - | Fax: (     )     - | | |

Purpose for the disclosure: co-ordination of treatment

Information to be released/disclosed: (Information to be disclosed **MUST** be initialed)

\_\_\_\_\_\_\_ Psychological History

\_\_\_\_\_\_\_ Progress Notes

\_\_\_\_\_\_\_ Psychological evaluation or reports

\_\_\_\_\_\_\_ Chemical dependency information

\_\_\_\_\_\_\_ Diagnosis / Medical records

\_\_\_\_\_\_\_ Treatment Plan or Summary

REQUIRED STATEMENTS:

You do not need to sign this authorization. Refusal to sign the authorization will not prevent you from receiving mental health and/or drug and alcohol treatment with PDX Mental Health Resources, LLC, unless: the health care services are solely for the purpose of providing/obtaining health information to someone else and the authorization is needed to make the disclosure. This authorization will expire at the termination of treatment

You may end this authorization in writing at any time. If you revoke your authorization, the information described may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made cannot be undone. To revoke this authorization, please request the form from provider. Complete the form and return it to your provider.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal low. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

|  |  |
| --- | --- |
| Patient Signature: | Date: |