Weitman Psychological Services, P.C.

19995 S.W. Stafford Rd., Suite F
West Linn, OR 97068

Phone: (503) 684-1483
Email: garen@drweitman.com

Authorization for Release of Confidential Information

This authorization must be written, dated and signed by the consumer or by a person authorized by law.

Name: ____ Date of Birth: ____________________

I will authorize Weitman Psychological Services to: ☐ Release information to, and/or ☐ Receive Information from:

____

(Person/Organization) *(Telephone Number)*

____

(Address)

Information will be used on my behalf for the following purpose(s):______________________________

By ***INITIALING*** the spaces below, I specifically authorize the release of the following medical/mental health records. The information to be disclosed includes (must be **initialed** by client and/or legal representative.

YES	NO	
_______	_______	Social, medical, or psychological reports
_______	_______	Medication(s) used in treatment
_______	_______	Treatment goals and results
_______	_______	** Information about drug and/or alcohol abuse
_______	_______	** Mental health information
_______	_______	** HIV/AIDS related records
_______	_______	Other (specify) ______________________________

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law my restrict redisclosure of HIV/AIDS, mental health, drug/alcohol or genetic testing information.

I understand that this information may be shared via phone, fax, written, email or in person. The information being shared will be the minimum amount necessary to accomplish the purpose of this authorization. Weitman Psychological Services, P.C. is not requiring that you sign this authorization. Refusal to sign this will not affect your ability to access health services.

I understand that I may revoke this authorization either in writing or verbally at any time. If I revoke my authorization, the information described may no longer be used to disclose for the purpose described in this written authorization. Any use or disclosure already made with my permission cannot be undone. Please send written revocations to: Weitman Psychological Services, P.C., 19995 S.W. Stafford Rd, Suite F, West Linn, OR 97068.

I have read this authorization and understand it. Unless revoked, this authorization will remain in effect for the duration of my treatment with Weitman Psychological Services, or expires one year from the date of signature (whichever comes first).

*** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal regulation also restricts any use of the information to criminally investigate or prosecute the patient.*

____________________ ____

Date Signature of client/guardian

____

Relationship to client if signed by guardian Reason client is unable to sign

______________________________ ____________________

Witness signature Date