Willamette Valley Family Center, LLC
610 JEFFERSON ST, OREGON CITY, OR 97045
503-657-7235 FAX # 503-657-7676

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Willamette Valley Family Center, LLC to release/receive the following information for the purpose of continuing mental health care for:

_____ _____.
(name of patient) (date of birth)

The information may be received from/released to: _____
_____
(list name and address of person or organization) _____
_____

The information that may be released/received consists of:

_____ Intake Information
_____ Client Information
_____ Intake Evaluation
_____ Diagnosis
_____ Testing/Assessment/Evaluation
_____ Other: _____
(please explain – may not be psychotherapy notes)

_____ Psychiatric Medication
_____ Progress Notes
_____ Treatment Plan
_____ Termination Summary
_____ Billing Dates

The purpose of the release of this information: _____
_____

Mental Health	Drug/Alcohol	HIV/AIDS
I understand that the information contains mental health/psychiatric information.	I understand that my alcohol and/or drug treatment records are protected under federal regulations (42 CFR Part 2 and ORS 430.399 (5) 179.505) governing Confidentiality of Alcohol and Drug Abuse Patient Records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.	I recognize that the information released may contain information regarding HIV/AIDS testing, treatment, or high risk behavior. (ORS423-045(3) and OAR33312270) I specifically consent to its release.
X_____ Signature	**X**_____ Signature	**X**_____ Signature
X_____ Date	**X** _____ Date	**X**_____ Date

This authorization ends on the following date:_____ or after the following specific event: _____

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at Willamette Valley Family Center. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

OPTIONAL:
You may request in the space below that we require the recipient of the information to sign a confidentiality agreement in which the recipient agrees to limit its uses and disclosures of your information to only those permitted by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement as you have requested, we will not release the information.

I request that the recipient of the information identified above sign a confidentiality agreement.

Signature: _____

Date: _____

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organization named in this form.

Signature:_____

Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
Print Name

_____
Signature

Relationship to Individual Patient:
_____Date:_____

YOU HAVE THE RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT