Eastside Child & Family Therapy

RELEASE OF INFORMATION

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Legal Name:	Preferred Name:	Date of Birth:

I hereby authorize: Eastside Child and Family Therapy, LLC
320 N Main Ave, Suite 201-A, Gresham, Oregon 97080
Fax: 503-405-4239/ Office: (503) 208-5288

To release information to and/or To receive information from

Person:	Organization:
Address:	
Phone Number::	Fax Number:
Email Address:	

The following information: (initial all that apply)

____Mental Health Evaluations	____Developmental and/or social history	____Educational Records	____Treatment Plans
____ Medical Records	____ Progress Notes	____Discharge/Transfer Summary	____ Other:

initial_____I recognize that the information released may contain information regarding mental health treatment that is protected by state law (ORS 179.505 & 192.505, 45 CFR 205.50). I specifically consent to its release.

initial_____I recognize that the information released may contain drug/alcohol information that is protected by federal and state law. [42CFR2.31, ORS 430.399(5) & 179.505]. I specifically consent to its release.

Eastside Child &

Purpose of such disclosure: (Initial all that apply)

____Treatment Planning	_____Referral/ Consultation	_____Legal Issues	_____Coordination of Care/ Case management
_____Diagnosis and Evaluation	_____Coordinate Aftercare/Ongoing Treatment/Services	_____Facilitate Health Benefit Utilization/ Billing/Scheduling	_____Other:

The individual signing this form agrees and acknowledges the following:

(i) Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
(ii) Effective Time Period: This authorization shall be in effect for one year after it is signed ***unless a specified termination date it requested***: Month: _____ Day: _____ Year: _____.

(iii) Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

SIGNATURES

Client/Legal representative:_____Date:_____

If Legal representative, relationship to client:_____