105 E. Hilliard Lane, Eugene, Oregon 97404 / / /
Phone: (541) 780-6836 / / / Fax: 541-543-2230 / / / admin@elrodcenter.org

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Name:___________________________________ DOB_______________

This is to authorize the TWO-WAY release of verbal and/or written information with:

FACILITY/COMPANY/AGENCY/INDIVIDUAL:

____

ADDRESS:____

CITY:___________________________STATE:
__________ZIP:__________

PHONE: ___________________________ E-MAIL: ____________________

SPECIFIC INFORMATION AUTHORIZED FOR RELEASE

(Client/Parent/Legal Guardian to initial next to the information that they wish to release)

_____Confirmation of Admission
_____Bio-Psycho/Social Evaluation
_____ISSP, ISSP Reviews
_____Individual Service Note
_____Attendance/participation
_____ Monthly written reports
_____Clinical Impressions
_____School/education related info

I understand that my records are protected under the federal regulations governing Confidentiality of ("HIPAA"), 45 C.F.R. parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that information used or disclosed pursuant to this consent may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand that I may revoke this consent verbally or in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:___________________

I understand that I have the right to obtain a copy of this authorization.

Signature of Client/Parent/Legal Guardian_________________________________ Date_________
Staff Signature: ____ Date_________

Prohibition of Redisclosure of Information Concerning Individuals in **Mental** Health **Treatment.** This notice accompanies a disclosure of information concerning a client in mental health treatment treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal **rules** prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by **the** written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this **purpose**.