WASHINGTON COUNTY
OREGON

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client's name:_____

Also known as: _____ **Birthdate:** _____

I AUTHORIZE THE RELEASE OF INFORMATION FOR THE PURPOSE OF:

☐ **Coordination of Client Services**

☐ **Other**_____

EXCHANGE OF INFORMATION BETWEEN THE PARTIES BELOW

NAME OF AGENCY OR INDIVIDUAL (Physician, clinic, hospital, attorney, etc.)	PHONE NUMBER	FAX NUMBER

INFORMATION THAT MAY BE RELEASED (Client Initials):

____Psychological/Psychiatric Evaluations **____ Alcohol/Drug history & treatment records**

____ Medical & Treatment Records including hospital(s) **____Other specific information as indicated** _____

_____

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization. My consent may be revoked at any time; the only exception is when the action has already occurred as instructed in the consent. This consent will expire one year after the date of signature. I understand that if my information is released to an entity not covered by federal privacy regulation it may be re-disclosed. *A copy of this form shall have the same validity as the original.*

I understand that substance use disorder records may be protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2) and cannot be re-disclosed without my written consent unless otherwise permitted or required by law.

Signature: _____ Date:

Department of Health and Human Services
Behavioral Health
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