Thriving Families
1230 NE 3rd St, Ste A-160
Bend, OR 97701
(541) 668-6891

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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

CLIENT'S NAME: _____ DOB: _____

I authorize Thriving Families: _____ obtain protected information from:
and/or
_____ provide protected information to:

Provider/Facility/Insurance Company: _____ Phone: _____

Address:_____

Service or Care They Provide(d):_____

By initialing each relevant space below I authorize information to be used on my behalf for the following purpose(s):

_____ Treatment Planning _____ Insurance/Quality Assurance/Utilization Review

_____ Continuity of Care _____ At the Request of the Individual

_____ Coordination of Care _____ Other _____

By initialing the relevant spaces below, I specifically authorize the release of the following mental health or medical records, if such records exist:

____ Intake summary and treatment plan ____ Consultations
____ School records ____ Psychological Records
____ Clinical Record ____ Medical records
____ Psychological testing reports ____ Other (specify)_____
____ Verbal or written summary of treatment, with diagnoses
____ Please send the entire medical record to the above named recipient. (The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.)

The authorization shall remain in effect until termination of treatment, or until _____ (if not filled in, it will remain in effect until termination of treatment).

I have carefully read and understand this authorization for release of protected mental health and medical records and I voluntarily authorize disclosure of these specified records for the purposes stated above. This authorization may be revoked, in writing, at any time. The only exception is when action has been taken in reliance on the authorization (see Notice of Privacy Policy and Informed Consent Agreement). Furthermore, I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA privacy rule.

_____ _____ _____
Authorized Party's Signature Printed Name Date