AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, (Name) _____ Date of Birth _____
authorize Faith Winters to use and disclose the specific protected health information described below regarding:

as is necessary to: ____ **release information to,** and /or ____ **receive information from**:

_____

_____

_____

Organization/ Person Address City State Phone

The information to be used or disclosed includes: (Please put your initials on each line for authorization)

____ Social, medical or psychological reports
____ Medications used in treatments
____ Appointment confirmations, Treatment goals and progress
____ Information about drug and /or alcohol abuse or treatment
____ Court of probation records
____ Pastoral relationship
____ Other _____

This information disclosure is necessary for the following purpose(s):

____ Diagnosis and evaluation
____ Treatment planning
____ To facilitate treatment
____ Other _____

If we are requesting this authorization from you for our own use and disclosure and to allow another health care professional or health care entity to disclose information to us: (1) We cannot deny our services or treatment to you if you refuse to make this signed authorization; (2) You have thee right to inspect a copy of the protected health information to be used or disclosed; (3) You may refuse to sign this authorization; and (4) we must provide you with a copy of the signed authorization. You have the right to revoke this Authorization at any time provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization. Unless revoked earlier or otherwise indicated this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

By signing this Authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners, health plans and other health care entities observe under state and federal law. The disclosure of information specified above may carry the potential for unauthorized disclosure of your protected health information and loss of protection under state; and federal law.

You may request that we require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclose of your information as specified by the Confidentiality agreement. If the intended recipient refuses to sign the Confidentiality Agreement you request, we will not release the information.
"I request that the recipient of the information identified above for disclosure sign a Confidentiality Agreement. ____"

____I understand that my alcohol and/or drug treatment records are protected under federal and state 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 authorization unless otherwise provide for in the regulations.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:
Specify the date, event, or condition upon which the authorization expires _____ (at the end of therapy)

X_____
Client or legal representative (describe legal representative's authority) Date

_____
Witness Date