

Portland Dialectical Behavior Therapy Program, PC

5125 SW Macadam Ave, Suite 145
Portland, OR 97239
Voice: 503-231-7854; Fax: 503-231-8153



Name: internal use EXT: only

- DBT is **SENDING** Records
- Keep Release on **FILE** for Future Use
- DBT is **REQUESTING** Records

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

A. By signing this form, I, (client's full name) Sally Jones authorize the use and disclosure of my individually identifiable health information to/from:

Dr. Paul Smith 503-452-8182

Person and Agency Represented (if applicable)

1512 Alpine Lane Portland, OR 97202

Address and Phone/Fax Number

B. Purpose of Disclosure: Mental Health Treatment Planning and Continuity of Care. Health information that may be used or disclosed through this authorization is as follows:

- Assessment/Treatment/Coordination of Care
- Eligibility Determination
- Legal/Court/Corrections/Probation
- At the request of the client
- Other: _____

C. Specific Information to be Disclosed: By initialing next to a category listed below, I specifically authorize use of confidential information.

- Psychiatric and Mental Health information as included in the records.
- Alcohol and Drug Treatment information (Specifically protected under law)
- AIDS/HIV/ other STD testing information (Specifically protected under law)
- All health information about me as described above, *excluding* the following: _____
- Specific health information including only: _____

D. I give permission to release my records from the following dates:

01/01/2000
(approximate start date of treatment)

present
(approximate end date of treatment)

D. I understand that my records are protected under the federal and state confidentiality regulation, including HIPAA, CFR 42 Part 2, RCW 71.05, 70.02, 71.34, 74.04, 13.50.100(4)(b) and WAC 388-865-0436 or its successor, and can not be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time, but that in any event this consent expires automatically in **180 days** or shall remain in effect for the period of time reasonably needed to complete the request. I understand that I may refuse to sign this authorization and that such refusal will not affect my ability to obtain treatment from Portland Dialectical Behavior Therapy Program.

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this authorization

Date 9/01/2006 Signature of Client Sally Jones
 Print Client's Full Name Sally Jones
 Client's Birth Date 08/1/57 SS#: 555-42-6661

Date _____ Signature of Parent/Legal Representative* if a minor
 *When client is not of legal age or competent to give consent, the signature of Parent or Legal Representative:

E. Redisclosure: If you give us permission to share your information with others, they may share your information without your consent. We cannot ensure that your information will be protected by others. However, some instances of State and/or Federal law may protect your information from being shared with others if it is information about HIV/AIDS, mental health, genetics, or drugs/alcohol.

F. Information about treatment, payment, and insurance: If your written permission to release health information about you is needed to determine your eligibility for medical programs and you do not give us permission to release your health information, then you may not be able to show that you are eligible. If another health care provider has asked us to provide a health care service to you, such as a test or evaluation, and you do not give us written permission to release your information to them, then we may not provide you with that health care service.

To the recipients of protected health care information: The information that has been disclosed to you from this authorization is protected by State laws (ORS 179.505, 192.525) and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not re-disclose this information with the written authorization from the person to whom the information pertains, or otherwise in accordance with the law.