Lutheran Community Services NORTHWEST
Health • Justice • Hope

## AUTHORIZATION TO USE / EXCHANGE HEALTH INFORMATION

**Multicultural Counseling Program** **605 SE 39th Ave. Portland OR 97214 Phone (503) 231-7480 Fax (503) 731-9574**

Client's Name (Last, First, Middle) _____

Client's DOB_____ Client's Home Phone_____

Client's Address, City, State, Zip_____

I authorize the following individual or agency to provide/exchange the following information with LCSNW:
If records cannot be provided at no charge, do not fill this request box.

Name_____Phone_____Fax_____

Address_____City_____State_____Zip_____

_____(By initialing here) I AUTHORIZE THIS RELEASE OF INFORMATION TO INCLUDE any information about MENTAL HEALTH treatment or evaluation, to include information pertaining to sexual assault, child abuse and neglect, hospital records, medical records, laboratory reports and school records.

_____(By initialing here) I AUTHORIZE THIS RELEASE OF INFORMATION to INCLUDE any ALCOHOL/ DRUG/GAMBLING diagnosis, treatment and prognosis information. I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations (CFR) governing confidentiality of alcohol and drug abuse patient records. Recipients of this information may re-disclosure it only with my written consent or as permitted by 42 CFR Part 2.

_____(By initialing here) I AUTHORIZE THIS RELEASE OF INFORMATION TO INCLUDE any HIV (AIDS) diagnosis, treatment and prognosis information.

[This Box MUST be Completed for All Requests for Information] ☐ check here for VERBAL information exchange only

**CLIENT** Please INITIAL after "How Much" and "What Kind or Description" to authorize quantity / type of information to be disclosed: How Much information is to be disclosed: Last 6 mo_____Last 1 yr_____Last 2 yrs_____All_____Other_____

What Kind of Description of information is to be disclosed: Treatment Plan_____Assessment_____Progress Notes / Reports_____

Medical Orders / Notes____ Psych Eval.____ Lab Work / Test Results ____ Discharge Summary_____ Other_____

PURPOSE OF DISCLOSURE: I authorize LCSNW to use / exchange my health information noted above for the purpose of evaluation, treatment planning, service coordination, and monitoring and treatment referral. *If this Authorization is to be used for additional purposes, or purposes other than those noted here, please indicate below*

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****I understand LCSNW cannot guarantee information will not be disclosed, if the information is released to an organization NOT SUBJECT to Federal and State laws.****

TERMS: I understand that **I may revoke this authorization** at any time except to the extent that action has been taken in reliance upon it. I understand that I may refuse to sign this authorization, and that refusal to sign this authorization may affect LCSNW's ability to coordinate and obtain services. Without my express revocation, this **Authorization will expire 1 year from the date of signing** or shall remain in effect for the period reasonably needed to complete the request, unless otherwise specified below:

_____This Authorization is limited to the following time period or until the following event occurs:_____

I have read and understood the terms of the Authorization and I have had an opportunity to ask questions about the use and exchange of my health information. By my signature, I hereby, knowingly and voluntarily authorize LCSNW to use or exchange my health information in the manner described above.

**Signature of Client**_____**Date**_____

**Signature of Authorized Personal Representative** _____
Note: If Client is a minor or is otherwise unable to sign this Authorization, obtain the following signature:

**Relationship to Client**_____**Date**_____

*Provide a copy of signed Authorization to Client *File Original in Client's Chart