PO Box 16308
Portland, OR 97292
Phone: 503-427-2394 Fax: 503-454-0763

Authorization to Use and Disclose Protected Health Information

Client Name: _____ Date of Birth: _____

Northwest ADHD Clinician Name(s): _____This release is also valid for other behavioral and medical clinicians at Northwest ADHD Treatment Center who may provide care to the above mentioned patient.

With my signature below, I authorize Northwest ADHD Treatment Center to:

(please check one or both) ☐ obtain information from: ☐ disclose information to:

Provider/clinic/other third party _____

Relationship to patient (Primary Care provider, spouse, etc) _____

Address _____ Telephone _____

City, State, Zip _____ Fax _____

Information which may be used/disclosed:

Initial: _____ Assessment and evaluation Initial:_____ Treatment Plan Initial:_____ Progress Notes

Initial: _____ Scheduling only Initial:_____ Medical Records (last 2 years unless otherwise noted)

Initial: _____ Other - please describe _____

I understand that additional laws about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand & agree that this information will be disclosed if I place my initials in the applicable space.

Initial: _____ Mental health information

Initial: _____ Genetic testing information

Initial: _____ HIV/AIDS information

Initial: _____ Drug/alcohol diagnosis, treatment, or referral information

I understand that I am not required to sign this authorization. If I refuse to sign this, it will not prevent me from getting mental health treatment at Northwest ADHD Treatment Center. The only exception is if the services I am seeking are only for providing health information to someone else and this authorization is needed to make the disclosure.

I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the purposes described here. If Northwest ADHD Treatment Center has already used or disclosed information, that cannot be undone.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

To revoke this authorization, please send a written statement to the office manager at the address or fax number listed above and state that you are revoking this authorization.

Unless revoked, this authorization expires 90 days after the completion of treatment or _____.

Client signature: _____ **Date**: _____

Parent/Guardian/Representative signature: _____ **Date:** _____

If Parent, Guardian, or Representative, print name:_____

Relationship to client (circle): Parent Legal guardian Power of Attorney/Healthcare Other: _____