Authorization to Use and Disclose Protected Health Information

Northwest ADHD Treatment Center
PO Box 16308 , Portland, OR 97292
Direct Email (Clinics Only): NorthwestADHDTreatmentCenter@insyncdirect.com
East Portland: *Phone:* 503-255-2343 ● *Fax:* 503-255-2344
Downtown Portland: *Phone:* 971-251-9856 ● *Fax:* 503-206-6713
Tualatin: *Phone:* 503-427-2394 ● *Fax:* 503-454-0763

Patient Name: _____Date of Birth: _____

Northwest ADHD Clinician Name(s): _____
This release is valid for all Northwest ADHD Treatment Center clinicians who may be involved in patient's care.

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

☐ Request records/information **from**: ☐ Send records/disclose information **to**: ☐ **Verbal only.**

Provider/clinic/other third party: _____ Relationship: _____

Address: _____ Telephone: _____

City, State, Zip: _____ Fax: _____

Select the information which may be requested/disclosed:

_____Assessment & Evaluation _____Treatment Plan _____Progress Notes _____Lab Results

_____Medication History _____Complete Medical Record (past 5 years) Other:_____

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 (Including psychotherapy notes)

Initial: _____ Genetic testing information

Initial: _____ HIV/AIDS information

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

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: _____