Authorization to Use and Disclose Protected Health Information

Downtown Portland: *Phone*: 971-251-9856 *Fax*:503-206-6713
East Portland Office: *Phone*: 503-255-2343 *Fax*: 503-255-2344
West Portland Office: *Phone*: 503-427-2394 *Fax*: 503-454-0763
Direct email : Northwest ADHDTreatmentCenter@insyncdirect.com
(Provider use only)

PO Box 16308, Portland, OR 97292

PROFESSIONALS: You are receiving this because your current or former patient is seeking evaluation or treatment at Northwest ADHD Treatment Center. If the individual has authorized NW ADHD to request records and obtain information from your organization, please send all relevant records and at least available records within the past 5 years, unless otherwise noted below. Please send the records at the earliest convenience to facilitate care. Thank you.

PATIENTS: Northwest ADHD Treatment Center needs medical records from your primary medical care provider (doctor) to help complete the ADHD evaluation process. Please be sure you complete this form for your primary medical provider, and complete it again as many times as needed for any current or recent mental health providers, friends or family members, or other individuals or entities you would like NW ADHD Treatment Center to communicate with.

Northwest ADHD Patients are entitled to access to their full records at any time. You may use this form at any time to request all or part of your health information on file to date. Your health information may also be available to you already through your portal account.

Patient Name: _____ **Date of Birth**:_____

NW 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:
(Multiple boxes may be checked)

☐ I authorize NW ADHD Treatment Center to **REQUEST** records and **OBTAIN** information **FROM** the party listed below

☐ I authorize NW ADHD Treatment Center to **SEND** records and **PROVIDE** information **TO** the party listed below

Verbal communication **ONLY** (No exchange of records)
CHECK IF NEEDED:

☐ I am requesting my **OWN** health records from NWADHD. (Specify information requested below, for example, "Diagnostic Verification Letter."). Personal health records will be made available to you through your patient portal account. If you would like your personal health records provided in a different way, please note how you would like to receive them below.

Personal Health Records Requested: _____

Continued on the Next Page

Provider / Clinic/ Other 3rd Party Information

(If requesting your Personal Health Records Only, Please skip to the bottom of this form to sign and date)

Provider/ Clinic/ Other 3rd Party: _____

Relationship to Patient :

(Medical Provider, Mental Health Provider, School, Spouse, etc): _____

Provider/ Clinic/ 3rd Party **Address**: _____

Provider/ Clinic. 3rd Party **Phone Number**: _____ **Fax:** _____

INFORMATION WHICH MAY BE USED/ DISCLOSED:

Place Initials Next to Each Type of Information That You Consent to Request or Disclose:

_____ Diagnostic Evaluation Records _____ Treatment Plan _____ Progress Notes _____ Medical Records

_____ Other (Describe): _____

I understand that other laws about sharing of 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 below:

Initial for Mental Health Information: _____ Initial for Genetic Testing Information: _____

Initial for HIV/AIDS Information: _____ Initial for 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 the 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. You can revoke this release by sending written notice to our office staff or your provider.

Patient Signature: _____ Date: _____

If Necessary:

Parent/ Guardian/ Representative Signature: _____ Date:_____

Print Name of Parent/ Guardian/ Representative: _____

Parent/ Guardian/ Representative's relationship to patient : _____