AUTHORIZATION & CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Anne Emmett LCSW

516 SE Morrison, Suite 500

Portland, Oregon 97214

Phone: 503-238-2405

I authorize Anne Emmett LCSW to: (initial all that apply)

_____Verbally or electronically exchange information to:

_____Receive and or send a copy of my health information to:

To/From:_____

I authorize this information to be used for: (initial all that apply)

_____continuation of mental health care

_____coordination with medical/health providers

_____legal issues (specify)

_____completion of evaluation

_____other (specify)

I authorize the exchange of the following information: (initial all that apply)

_____Mental health session notes

_____Mental health treatment summary

_____Billing records

_____Coordination of care via phone call/electronic record

_____Alcohol and drug information

_____Genetic information

_____HIV information

I understand that any information that is exchanged with another person will be protected if that person is required to comply with the Federal Privacy Rule If privacy laws do not apply, the information may not be protected and could be re-disclosed without authorization.

I understand that I may refuse to sign this authorization. My refusal to sign will not prevent me from receiving mental health services or reimbursement for services. The only exception is if the services are solely for the purpose of providing information to someone else and this authorization is necessary to make that disclosure.

I understand that I may revoke this authorization at any time and that if revoked this form is no longer valid. The only exception is when the authorization was obtained as a condition of obtaining insurance coverage. Any information that had been exchanged prior to a revocation cannot be retrieved. To revoke this authorization, please send a written statement to Anne Emmett LCSW.

Unless revoked, this authorization will expire in:

_____one year

_____other/specify

_____upon termination of mental health treatment

I have read this authorization and I understand it. This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

Signature of client or client's legal representative: _____

_____

Description of representative's authority: _____

_____

Date: _____

Significant information: Information used or disclosed under this authorization may be subject to redisclosure by others without your permission. In some instances federal and state law may protect your information from being shared if it is HIV/AIDS, genetic information or alcohol/drug related.

To the recipients of protected health information: The information disclosed to you by this authorization is protected by state law (ORS 179.5015,192.525) and Federal regulations (42 CFR Part 2.45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of drug and alcohol treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.

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