Willamette Health &Wellness, LLC

700 NE Multnomah St., Suite 275
Portland, OR 97232
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For Office Use Only

PT ID _____________

Reviewed __________ Date ___ / ___ / _____

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Name: ____ DOB: _________________
(Individual whose information is to be disclosed)

I authorize Willamette Health & Wellness, LLC to exchange information with the following individual(s) or agency:

____
(Name of facility or provider) (Address)

____
(Phone) (Fax number)

Relationship to Patient

☐ Primary Care Provider ☐ Other ______________________

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

Initial ________ HIV/AIDS information
Initial ________ Genetic testing information
Initial ________ Mental health information
Initial ________ Drug/alcohol diagnosis, treatment, or referral information.

Consisting of all health information unless otherwise specified here: ____

Purpose of disclosure: This information will be used for evaluation and to plan for and coordinate services for me, my family or for other purposes specified here: ____

This authorization becomes effective on the date below and will expire 90 days from termination of treatment with Willamette Health & Wellness, LLC unless I indicate otherwise: ☐ Specific expiration date: ______________________

I understand that I do not have to sign this authorization. Refusal to sign this authorization will not adversely affect my ability to receive health care services or reimbursement of services. I have a right to refuse to sign this authorization. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

I also understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. However, I also understand that federal or state law may restrict disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I have the right to revoke authorization in writing except to the extent that Willamette Health & Wellness, LLC has acted in reliance upon it. My written revocation must by received by Willamette Health & Wellness at 700 NE Multnomah St, Suite 275, Portland, OR 97232.

______________________________ __________ ____________________________________ __________
Client Signature Date Parent or Guardian Signature (if applicable) Date

Re-disclosure: Information received under this authorization should not be re-disclosed to any party not identified on this form without specific written consent. Criminal penalties may apply to illegal disclosure. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosures of Alcohol/Drug Information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.