

Kim E. Lucey, LCSW
1962 NW Kearney St. Suite 204
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971-225-0105 (p)
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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: _____ (Name of person disclosing information) to use and disclose specific health information described below regarding: _____ (Patient Name)

To: _____ (Name of recipient) for the purpose of:

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.

- _____ Entire Mental Health Chart
- _____ Mental health testing information
- _____ Mental health treatment information - summary
- _____ Drug/alcohol diagnosis, treatment, or referral information.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDs information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you 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. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

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To revoke this authorization, please send a written statement to Kim Lucey, LCSW at 1962 NW Kearney St. Suite 204, Portland Oregon 97209. Unless revoked earlier, this consent will expire _____ days/year from the date of signing or shall remain in effect for the period reasonably needed to complete the request. I have read this information and I understand it.

Unless revoked, this authorization expires _____ (insert either applicable date or event).

Patient Signature

Date