CONFIDENTIAL INFORMATION

new leaves
CLINIC

Release of Information

This form authorizes a release of protected information from your clinical record to the person you designate.

Patient Name:

I authorize *New Leaves Clinic* to release: **All mental health treatment notes, treatment plans and assessment reports.**

This information should only be released to:

Agency/Person to be released to:

I am requesting my psychologist release this information for the following reasons: **Assessment & Treatment Planning.**

I authorize the party below to release: **All mental health treatment notes, treatment plans and assessment reports**

Agency/Person to be released to:

This information should only be released to:

New Leaves Clinic	Phone: 503.274.0996
1500 NW Bethany Blvd, Ste. 200, Beaverton, OR, 97006	Fax: 503.597.1313

I am requesting my psychologist release this information for the following reasons: **Assessment & Treatment Planning.**

Information listed below has additional laws relating to their use and disclosure.

*I understand and agree that this information will be disclosed if I place my **initials** below.*

_____ **Mental Health Information**	_____ **Drug / Alcohol Diagnosis, Treatment & Referral Information**
_____ HIV / AIDS Information	_____ Genetic Testing Information

- I 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.
- This authorization shall remain in effect for the duration of my work at New Leaves Clinic or unless I revoke it in writing.
- To revoke this authorization, please send a written statement to New Leaves Clinic, 1500 NW Bethany Blvd., Ste. 200, Beaverton, OR 97006 and state that you are revoking this authorization. This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance.
- I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA privacy rule.

_____ Client Signature

_____ Date