CONFIDENTIAL INFORMATION

new leaves
CLINIC

Reciprocal Release of Information

Client's Name:

This is a Reciprocal Release of Information: ***This form authorizes the patient's/client's protected health information to be given to and received from the agencies/people listed below.***

- I authorize *New Leaves Clinic* & its Independent Contractors & the agencies/people listed below to release all mental health/medical/academic treatment notes, treatment plans and assessment reports.
- I am requesting this information be released to assist in diagnosis, assessment, planning, therapy and/or mentoring.
- This form authorizes both parties to receive and give protected health information about this patient/client.

Below are the agencies / people allowed to both release and receive the patient's protected health information:

New Leaves Clinic & our independent contracted providers 1500 N.W. Bethany Blvd, Ste. 200 Beaverton, OR, 97006	*Phone:* 503.274.0996 *Fax:* 503.597.1313

Write the name & contact information of the other agency/person.

The information listed below has additional laws relating to its use and disclosure. By initialing the spaces below, you state that you understand and agree that the following protected health information may be disclosed.

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

- 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 until revoked in writing by a legally authorized patient/parent/caregiver. 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/provider 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.

Signature _____ Date _____

Updated 6.13.2013