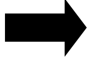
CONFIDENTIAL INFORMATION

Reciprocal Release of Information



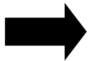
Write the patient's name.

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

- I authorize *New Leaves Clinic* and 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, treatment planning & therapy.
- This form authorizes both parties to receive and give protected health information about this patient.

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

New Leaves Clinic 1575 N.E. Arrington Road, Hillsboro, Oregon 97124	*Phone:* 503.693.9153 *Fax:* 1.844.732.5389



Write the name of the other agency/person.
Please include fax and phone numbers, if possible.

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 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, 1575 N.E. Arrington Road, Hillsboro, Oregon 97124 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.

Signature

Date