New Perspectives Center
for Counseling and Therapy
1675 Winter Street NE, Salem, OR 97301
(503) 316-6770 Fax (503) 585-0212

AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization must be written, dated, and signed by the individual client or by a person authorized by law to give authorization.

To Our Clients: We are required by Federal law to comply with the Health Insurance Portability and Accountability Act (HIPAA). We can help you better if we are able to work with other agencies / individuals that know you and your family.

Name ______________________________ DOB ________________ ID # ________________
Client Name (Use SS # for Employment and Vocab Rehab)

I authorize the following individual or agency:

______________________________ ______________________________
(Name of Facility or Provider disclosing information) (Address)

______________________________ ______________________________
(Phone) (Fax Number)

To provide information to:

NEW PERSPECTIVES CENTER 1675 Winter Street NE
(Name) (Address)

503-316-6770 503-585-0212
(Phone) (Fax Number)

By <u>initialing</u> the space below, I specifically authorize the release of the following medical records, if such records exist:

______ Mental Health Services (*including assessment, diagnosis, treatment plan, progress notes, and discharge information)*
______ HIV/AIDS related records
______ Alcohol/Drug diagnosis, treatment, or referral (*Federal regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information below.)*
______ Medical/Psychiatric Treatment
______ Other/description ______________________________

I agree that the agencies and individuals listed above may share and exchange information about my family and my circumstance. **Please <u>initial one</u>**. ______ Yes ______ No

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me, my family or for other purposes as specified: ______________________________

Note: If requested by the client, purpose may be listed as "at the request of the individual."

This permission is good for: ☐ 1 year ☐ Until the date of ___/_____/____

I understand that I do not have to sign this authorization to receive treatment from New Perspectives Center. In fact, I have the right to refuse to sign this authorization. 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. I have the right to revoke this authorization in writing except to the extent that New Perspectives Center has acted in reliance upon it. My written revocation must be submitted to the Privacy Officer at New Perspectives Center, 1675 Winter Street NE, Salem, OR 97301.

☐ Client ☐ Guardian ______________________________ ____________
☐ Parent ☐ Legal Custody Signature Date

Redisclosure: Information received under this authorization should not be redisclosed 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 and Drug information without the 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.

For People Who Cannot Write

I understand this form and am completing it voluntarily. I cannot write. I am placing my mark by my name to sign this form.		
My Mark:	Full Name of Client	Date

Witness #1	Address
Witness #2	Address

For People Who Cannot Read

I have read the form to the client. They understand it and have signed it voluntarily.		
Worker's Name	Signature	Date

*** Explanation:** Supplying the Social Security number is voluntary and in general the refusal to supply the Social Security number cannot be used to deny services. However, it is necessary for identifying records for Employment and Vocational Rehabilitation information. In either case, if supplied, the Social Security number may be used to enforce agency regulations.

INSTRUCTIONS

1. The worker should fill out this form for the client. Be sure the client understands it before signing. Encourage the client to ask questions about the form and what it allows.

2. **Mail Requests.** If this form is being used to request information by mail, be specific about what you need. If you have a series of questions, use a cover letter. The clearer you are in your request, the more likely you are to receive a prompt and accurate response. Do not ask for information you do not need.

3. **Family Records.** This release covers information about the person signing the form, minor children and information about the family he / she supplied for the record. It would not cover information supplied by other adult family members unless they also sign a release.

4. **Children.** Minors can consent to medical treatment at age 15, mental, emotional or chemical depending on treatment, at age 14. They may sign their own permission for release of information forms needed for such treatment.

5. **Photocopying.** Keep the original in the file and send copies to other agencies. The person making the photocopies should sign each copy at the bottom of the first page certifying it as a true copy. The agency receiving the authorization should reject it if there is not an original signature by the person who made the copy.

6. **Revocation.** If the person later cancels this authorization, write "revoked" and the method and date of revocation boldly across the form. Date and initial it, and keep in the file. Federal regulations require that the revocation be in writing.

7. **Duration.** The authorization is valid for one year unless otherwise specified. Check to be sure that the release you are using is still current.

8. **HIV.** This form should not be used to request information about HIV testing. Use the form developed by the Oregon Health Division.

9. **Guardianship/Custody.** If the signer is a guardian, a copy of the guardianship paper must be attached when the request is sent. Similarly, if an agency had custody, and their representative signs, the custody order should be included.

10. This is a **Voluntary** Form. However, clients should be given accurate information on how the refusal to allow the release of information will adversely affect eligibility determination or coordination of services. If the client decides not to sign, attempt to refer the family to a single service, which may be able to help them without an exchange of information.