Authorization to Release Protected Health Information

4424 NE Glisan
The Li Wellness Building
Portland, Oregon 97213
503-484-8608 (phone)
503-549-8684 (fax)
Hawkonchurch@gmail.com

_____
CLIENT'S FIRST, MIDDLE, AND LAST NAME AND DATE OF BIRTH

I,_____, hereby authorize
Name of Client/Guardian

Melvin L Hawkins, LCSW Counseling Services

- To give health records to
- To receive health records from
- To verbally exchange health information with

_____

Purpose: I authorize the exchange or disclosure of the health information for the following reasons:

-Continuity and coordination of care

_____

To or from (recipient or sender),

_____
Name of Individual/Organization

_____
Address

_____
Phone Number & Fax Number

By initialing or checking the spaces below, I specially authorize the disclosure of the following health information:

____Therapy case notes

____Medical records (progress notes)

____Medications records used in treatment

____School reports (IEP, 504, Behavioral health records)

____Treatment Plans

____Mental Health Assessment

____Discharge Summary

____Screening Tools, Other Assessments

I have been informed and fully understand that this protected health information may be in written, oral, or report form. I understand that the information used or disclosed related to this authorization may be subject to re-disclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and drug/alcohol diagnosis, treatment, or referral information.

I understand that I have the right to refuse to sign this authorization and that my refusal will not negate treatment, payment, enrollment, or eligibility for benefits. Client/Parent/Guardian may revoke this authorization at any time, but such revocation may not be retroactive. If you revoke this authorization, the information described above may no longer be disclosed for the purposes described above. To revoke this authorization, please inform me and line of revocation can be signed and dated below.

This Release of Information is good for one year to this date:_____

Printed name parent/guardian/client:_____

Signature parent/guardian/client:_____

Date _____

Revocation signature and date_____