Parrott Creek
CHILD & FAMILY SERVICES

Consent to Release and Receive Protected Health Information

CLIENT: DOB :

I hereby authorize and provide permission to the provider/individual listed below

☒ to release information to
☒ to receive information from
☒ to exchange information with

1.	Name: *Bob Smith CADC Counselor*	Drew Culver
2.	Agency: *Bob Smith A&D Treatment Center*	Parrott Creek Child & Family Services
3.	Address: *12345 ABC Street*	1001 Molalla Avenue Suite 209
	Anytown, OR 12345	Oregon City OR 97045
4.	Phone: *123-456-7890*	503-722-4110
5.	Fax: *123-456-7890*	503-655-8908

I give permission to the providers/individuals listed above to exchange my information in the following ways:

☒ Via discussion ☒ via facsimile ☒ via mail ☒ via e-mail

PURPOSE OF DISCLOSURE
Please check all that apply.

☐ Assessment/Treatment/Coordination of Care
☒ Program Eligibility Determination
☐ Court/Legal/Corrections
☐ Housing
☐ At the request of the client
☐ Other:

TYPE OF INFORMATION TO BE RELEASED

By **INITIALING** below, I specifically give permission to release my following records.

*_____ Assessments/Evaluations
_____ Progress Notes
_____ Current Mental Status
*_____ Medication Records
_____ Entire Record
_____ Other (specify)_____

____ Treatment/Service Plans
____ Psychiatric/Psychological Testing
____ Academic Records/Progress
*____ Laboratory Report
____ Housing/Lease Information

1. Counselor Name
2. Outpatient Treatment Name
3. Full address: City / State / Zip Code
4. Main phone #
5. Fax # (if available)

* Initials required for these records

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I give permission to release my records from the following dates:

1. _____ To _____

I understand I can revoke this consent at any time. However, my withdrawal of this consent is not retroactive to any action already taken. This consent, unless expressly revoked earlier, expires on:

___/___/___	The end of services
Date	Event or Condition

Information regarding re-disclosure of your health information: Be aware if you provide us permission to share your information with others, they may share that information without your permission. In some instances federal and state law may protect your information from being shared by others if it is mental health information, genetic information or drug/alcohol diagnosis, treatment, or referral information.

Information regarding your treatment, payment for treatment, enrollment in a health plan or eligibility for benefits: If another provider requests Parrott Creek Child & Family Services to provide services to you and you do not give us your written permission to release your information to them, we may not be able to provide you with that service.

2. _____

Client Signature Date

1. Today's date through one year later (i.e. 1/1/2023 to 1/1/2024)
2. Today's date