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

Name:	Name: All Staff
Agency:	Parrott Creek Child & Family Services
Address:	1001 Molalla Ave
	Oregon City, Or
Phone:	503-722-4110
Fax:	(503) 655-8908

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

___ Via discussion Sent ___ via facsimile Sent ___ via email
(Please note that email is not always a confidential form of communication)

PURPOSE OF DISCLOSURE
Please check all that apply.

____ Assessment/Treatment/Coordination of Care
____ Program Eligibility Determination
___x_ At the request of client
____ Legal/Court/Corrections/Probation
____ Insurance Eligibility Determination
____ 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 State
_____ Medication Records
_____ Entire Record
____ Treatment/Service Plans
____ Psychiatric/Psychological Testing
____ Academic Records/Progress
____ Laboratory Report
____ Other

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 one year from date signed

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.

Client Signature	Date
Parent Signature	Date
Legal Representative Signature	Date
Witness Signature	Date

***If other than Parent, PROOF OF LEGAL REPRESENTATION MUST BE PROVIDED in the form of a custody order, guardianship order or medical power of attorney.**

TO THE RECIPIENTS OF PROTECTED HEALTH INFORMATION

The information that has been disclosed to you from this authorization is protected by State laws (ORS 179.505, 192.525) and Federal regulations (42 CFR Part 2, 45 CFR parts 160-164). You are instructed that you may not re-disclose this information without the written authorization from the person to whom the information pertains, or otherwise in accordance with the State laws and Federal regulations.