WPCS WESTERN PSYCHOLOGICAL & COUNSELING SERVICES, P.C.

Authorization to Use and Disclose Protected Health Information

PO Box 82819, Portland, OR 97282
Phone: 503-233-5405 Fax: 503-233-2693

Client Name: ______________________________ DOB: _____/_____/_________

With my signature below, I authorize ______________________________ & WPCS to
☐ OBTAIN information from ☐ DISCLOSE information to

Contact Person: ______________________ Organization: ____________________
Address: ______________________ Telephone: ____________________
City, State, Zip: ______________________ Fax: ____________________

Information to be used/disclosed consists of mental healthcare information, including:

☐ Assessment or Evaluation ☐ Treatment Plan ☐ Notes ☐ Coordination of care information
☐ Other: __________

The purpose for the disclosure/communication:
☐ Coordination of care ☐ Other:______________________________

I understand that additional laws about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space.

Initial: _____ Mental health information
Initial: _____ Drug/alcohol diagnosis, treatment, or referral information
Initial: _____ HIV/AIDS information
Initial: _____ Genetic testing information

Other information

I understand that I am not required to sign this authorization. If I refuse to sign this, it will not prevent me from getting mental health or drug/alcohol treatment at Western. The only exception is if the services I am seeking are only for providing health information to someone else and this authorization is needed to make the disclosure.

I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reasons described here. If Western has already used or disclosed information, that cannot be undone. To revoke this authorization, I can request the form from Western's front office or my provider and return the completed form to my provider or the front desk.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization expires 60 days after the completion of treatment or: ____________________

Signature

I have read this authorization and understand it.

Client signature: ______________________________ Date:____________

Parent/Guardian/Representative signature: ______________________________ Date:____________

If personal rep, print name:______________________________

Relationship to client: ☐ Parent ☐ Legal guardian ☐ Power of Attorney/Healthcare ☐ Other____________