GLADSTONE MUNICIPAL COURT
525 PORTLAND AVENUE
GLADSTONE, OR 97027
(503) 557-2772
Fax (503) 650-8938

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____ _____
Date Client Name DOB

I hereby authorize and give my permission to the providers/individuals listed below to release a copy of my record to Gladstone Municipal Court:

Provider: Name: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Purpose for this disclosure (check all that apply):

☐ Assessment / Treatment / Coordination of Care ☐ Eligibility Determination*
☐ Legal/Court / Corrections / Probation* ☐ At the request of the client*
☐ Other* (specify)' _____

* Reasonable fees may be charged to cover the cost of preparing, copying and mailing your records.

I specifically give permission to release the following records:

☐ Assessments / Evaluations ☐ Progress Notes ☐ Psychiatric / Psychological Testing ☐ Admission / Discharge Summary
☐ Treatment / Service Plans ☐ Medication Records ☐ Academic Records / Progress ☐ Financial/Billing Records
☐ Current Mental Status ☐ Laboratory Reports ☐ Vocational Records ☐ ENTIRE RECORD
☐ Abstract (Diagnosis, Treatment Plan, Assessments, Evaluations, Progress Notes, current Medications, Psychiatric/Psychological Testing Records)
☐ Other (specify) _____

Release my records from the following dates: First Treatment Date: _____ to: Last Treatment Date: _____

RELEASE OF THE FOLLOWING RECORDS AND INFORMATION REQUIRES SPECIFIC AUTHORIZATION: By initialing the spaces below, I specifically authorize the voluntary release of the following medical records, if such records exist. I understand federal and state law protects them. ___ Mental Health Information _____ Genetic Testing Information ____Alcohol/Drug Records ____HIV / AIDS Information

I understand I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. A revocation will not affect inspection of records necessary to validate expenditures by or on behalf of government entities. To revoke this authorization, please send a written statement to Gladstone Municipal Court and state that you are revoking this authorization. Unless revoked earlier, by CHECKING one box below this consent will expire:

☐ 1 year from the date I sign OR ☐ upon the event or date indicated:,_____

_____ _____ _____
SIGNATURE (Client, Guardian, or Person Authorized To Sign for Client)' NAME-Please Print RELATIONSHIP TO CLIENT 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.

SIGNIFICANT INFORMATION: Information used or disclosed under this authorization may be subject to re-disclosure by others without your permission and is no longer protected under federal law. In some instances, federal and state law may protect your information from being shared if it is HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information. TO THE RECIPIENTS OF PROTECTED HEALTH INFORMATION: The information disclosed to you by this authorization is protected by state law (ORS 179.505, 192.518) and Federal regulations (42 CFR Part 2,45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol and drug treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.