AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (ROI)

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(HIPAA & Oregon-Compliant – Two-Way Authorization Including SUD History)

Client/Patient Information

Client Name: _____
Date of Birth: _____
Address:_____
City/State/ZIP:_____
Phone:_____

Authorization

I authorize the use and disclosure of my protected health information as described below. This authorization permits two-way communication between the providers listed.

FROM (Physician/Clinic/Facility):
Name:_____
Address:_____
Phone:_____ Fax: _____

TO (Your Practice / MedFT Office):
Practice Name:_____
Address:_____
Phone: _____ Fax: _____

Description of Information to Be Disclosed (Check All That Apply)

Entire medical record (including diagnosis and treatment plans)

☐ Most recent medical history (last 12 months)

☐ Medications and prescription history

☐ Lab results, imaging, and diagnostic testing

☐ Substance Use Disorder (SUD) history, assessment, and treatment records

(Initials: _____) Mental health records (Initials: _____)

☐ Progress notes relevant to treatment coordination

☐ Other (specify): _____

Purpose of Disclosure

☐ Treatment Coordination

☐ Continuity of Care

☐ Referral Follow-up

☐ Client Request

☐ Other _____

Expiration

This authorization will expire on (date): _____ OR upon the following event: _____

Revocation & Redisclosure

I understand that I may revoke this authorization at any time by submitting a written notice to the releasing provider. Revocation will not apply to information already disclosed. I understand that once disclosed, the information may be subject to redisclosure and may no longer be protected by federal or state privacy laws.

Signature

Client Signature: _____
Date: _____

If signed by Personal Representative:
Name: _____
Relationship to Client: _____
Authority (POA, guardian, etc.): _____