Providers of:
Oregon Psychiatric Partners, L.L.P.
3203 Willamette St. ~ Eugene, OR 97405
Phone 541-726-9912 ~ Fax 541-744-4443

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

Other Names Used: _____

For the purpose(s) of continuity of care, diagnosis, evaluation and treatment planning, I authorize my provider(s) at **OREGON PSYCHIATRIC PARTNERS, LLP,** to release the following confidential information about me to the physician or organization listed below.

_____
(Name of Physician or Organization)

_____
(Address) (Telephone) (Fax)

By placing my initials here _____ **I authorize the physician or organization listed above** to release my medical record and information to my provider(s) at OREGON PSYCHIATRIC PARTNERS, LLP.

I understand my record may include medical, mental health, and drug/alcohol diagnostic evaluations, treatment history, progress notes, summaries, medication history, laboratory test and reports, and hospital and immunization records.

I understand the following information can only be disclosed if I initial below. I further understand that federal and/or state laws prohibit the re-disclosure of mental health, drug and alcohol, and HIV/AIDS diagnoses and treatment information, and specific authorization is required for the release of such information.

_____ Mental Health records which may include drug/alcohol diagnoses and treatment or referral information
_____ HIV/AIDS related information and/or records
_____ Genetic Testing information and/or records

Type of Information to be released: *(Check One)*

- ☐ **All Chart Notes –** for continuity and coordination of care
- ☐ **Last 12 months of chart notes**
- ☐ **Medication Records**
- ☐ **Billing Statements**
- ☐ **Laboratory Reports**
- ☐ **Complete Medical Chart** – Includes all documents and communications
- ☐ **Other:** Please list below

If "Other" is chosen above, please list specific items to be released.

_____
_____

Please indicate the purpose for this release: *(Check One)*

- ☐ To allow mutual communication back and forth between my provider(s) at OPP and the entity listed above.
- ☐ To request and allow a one-time transfer of information from the entity listed above, so they may send it to OPP.
- ☐ To allow a one-time transfer of information from my record at OPP, so OPP can send it to the entity listed above.

This authorization will terminate: *(Check One)*

- ☐ When my care is terminated by my provider or myself.
- ☐ When the single event request has been fulfilled, which I understand may take 15 business days from the date of the request.
- ☐ On the following date: *(please enter date to terminate authorization)* _____

If you are requesting a specific record or date span to be released, please specify the document and/or date span below:

_____
_____

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By signing below:

I authorize the release of the medical records noted above and I understand the person or organization receiving these records could re-disclose the records and they may not be covered under federal privacy laws.

I understand that information about my care is confidential and protected by state and federal law and I may cancel this authorization at any time. To cancel the authorization, I must provide a written request to cancel. The request to cancel this consent will not affect information that was released prior to the date of my cancellation request.

I agree I have read the entire release, and I understand this authorization is voluntary and I may refuse to sign the authorization. I understand if I do not sign this authorization, it will not affect my ability to obtain treatment or payment or my eligibility for benefits.

_____	_____	_____
Date	Signature of Patient or Guardian	Type of Guardianship