Avant Mental Health, LLC
648 Chetco Avenue
Brookings, Oregon, US – 97415-8010

Release of Information

Avant Mental Health, LLC
648 Chetco Avenue, Brookings, Oregon 97415
Phone: 541-351-9149
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This document gives Avant Mental Health, LLC, including its practitioner(s) and authorized representatives, permission to communicate with the persons and/or entities identified on this release.

Authorization to Release and Obtain Confidential Records and Information

A. Identifying information about me/the patient

Name of Patient: * _____

Date of Birth: * _____

Current Phone Number: * _____

B. I understand that certain information cannot be released without specific authorization as required by state or federal law. Because I believe it is in my/our best interest, by initialing below I authorize Avant Mental Health, LLC, including its practitioner(s) and authorized representatives to release and/or exchange the following protected or sensitive personal health information:

_____ *(initial)* Entire record from person and/or organization listed in section C.
Example: Previous treatment history, medication history, and health assessments.

_____ *(initial)* Entire mental health record at Avant Mental Health, LLC, Example: appointments, psychiatric care, psychotherapy notes, medication list, assessments, diagnoses, recommendations, and all similar documents

_____ *(initial)* Social, family, developmental histories

_____ *(initial)* Alcohol and drug treatment records

_____ *(initial)* HIV status or test results

_____ *(initial)* Genetic testing information and results

_____ *(initial)* Other (specify) _____

C. I authorize the release and/or exchange of said information to the following agency (healthcare provider, therapist, employer, lawyer, school, family member, etc)

Name of person and/or organization: * _____

Address: *

Phone: *

Fax:

D. I authorize the transfer of these records for the following purpose(s) or uses:

1. Further mental health evaluation, treatment, or care
2. Treatment planning
3. Qualification for services or benefits
4. General Coordination of Care

E. I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to Avant Mental Health, LLC, except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. I authorize the release(s) of information to be conducted over telephone, email, text message, video chat and/or face to face, or faxes.

F. My consent is fully voluntary. If I refuse to sign this form, I understand that it will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or eligibility for health benefits.

G. I understand that the Source of the information (Avant Mental Health, LLC) has no control of the health information after it has left the Source's premises (i.e. shared by the receiving entity).

Name of Patient or Guardian: * _____

Signature of Patient or Guardian: *

_____

Date: * _____

Redisclosure: Notice is hereby given to the patient or legal representative signing this Authorization that Avant Mental Health, LLC, cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.