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
Fax: 503-914-6686

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 outside 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, medication list, assessments, diagnoses, recommendations, and all similar documents

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

_____ *(initial)* Alcohol and drug treatment records

_____ *(initial)* HIV status or test results

_____ *(initial)* Genetic testing information and results

_____ *(initial)* Other (specify): _____

Psychotherapy notes: This authorization does not include separately maintained psychotherapy notes. A separate authorization must be completed to authorize their release.

C. **I authorize Avant Mental Health, LLC and the person and/or organization identified below to disclose and exchange the information selected in Section B with each other for the purposes identified in Section D.**

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 I may revoke this authorization at any time by submitting a written request to Avant Mental Health, LLC at the address listed above, except to the extent that action has already been taken in reliance on this authorization. This authorization is effective on the date I sign it and expires one year after my discharge from care at Avant Mental Health, LLC, unless I revoke it earlier in writing. I understand that I may inspect or obtain a copy of the health information to be disclosed, as permitted by law. I authorize the information described in this form to be shared by telephone, email, text message, video conference, in person, or fax.

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).

Redisclosure: I understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA. Federal or state law may restrict further disclosure of certain information, including mental health, HIV/AIDS, genetic testing, and alcohol or drug treatment information.

Name of Patient or Representative: * _____

Signature of Patient or Representative: *

_____

Date: * _____

Complete the following only if a personal representative signs for the patient.

Representative's printed name: _____

Relationship to patient: _____

Legal authority to act for the patient: _____