RELEASE TO DISCLOSE CONFIDENTIAL INFORMATION

Regarding: ______________________________ ______________________
Client/Patient Name Date of Birth

I authorize the Children's Program, 6443 SW Beaverton-Hillsdale Hwy, Suite 300, Portland, OR 97221
Phone: (503) 452-8002 Fax: (503) 452-0084

☐ to exchange information with ☐ to receive information from ☐ to provide information to

☐ by mail ☐ by E-mail ☐ by Fax ☐ by telephone

____
Name (specific person, class of person or facility)

____
Mailing Address (must be complete to be processed)

______________________ ______________________ ______________________
E-mail Address Telephone Fax number

For the purpose of: ☐ Treatment Planning ☐ Coordination of Care ☐ Diagnostic Evaluation
☐ Other (please specify): ______________________________

YOU MUST BE SPECIFIC regarding the information you are requesting:

- ☐ Telephone Consultation between the Children's Program and ______________________
- ☐ Email Contact between the Children's Program and ______________________
- ☐ Developmental Pediatric Report Dated: ______________________
- ☐ Psychological Report Dated: ______________________
- ☐ Psychological Treatment Summary
- ☐ Speech Language Pathology Evaluation
- ☐ Educational Report Dated: ______________________
- ☐ Other: ______________________

(Please see the Confidentiality section of your Treatment Consent form regarding the release of chart notes.)

This authorization will expire on the earlier of __________ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose. You have the right to revoke this Authorization at any time in writing to your clinician or our clinic administrator. Identify the date you signed the Authorization, the recipient of the information identified, and state that you are revoking the Authorization. We cannot take back uses or reverse disclosures already made with your permission.

I have reviewed and I understand this Authorization. By signing this, I understand that I am directing you to disclose information to /receive information from a person or organization that may not have or obey the same obligations to protect privacy under state and federal law. The disclosure of the information specified above carries with it the potential of an unauthorized re-disclosure and loss of protection under state and federal law.

Communication by electronic, audio or video means, i.e. Fax, E-mail or Skype is not secure and presents a significant risk to patient confidentiality. By requesting exchange of information or communication by electronic means I acknowledge that I am aware of these significant additional risks to confidentiality and agree to assume these risks and know that confidentiality, review, re-disclosure, dissemination, distribution or copying of this information cannot be guaranteed.

______________________________ ______________________
Clients (ages 14 or older) Date

______________________________ ______________________
Signature for client/parent/guardian (for clients younger than 14) Date

THERE MAY BE A CHARGE TO PROVIDE RECORDS. REQUESTS FOR A CHART IN ENTIRETY WILL INCUR A MINIMUM CHARGE OF $25. A CREDIT CARD NUMBER MUST ACCOMPANY THIS REQUEST.

☐ Visa ☐ MasterCard ☐ Discover ☐ AMX Name of Cardholder: ______________________

☐ CC# ______________________ **Exp. Date** ____________ **Zip Code** ____________

12/2017