Authorization **REVOKED** on: _____

☐ Verbally by Client ☐ in Writing by Client

Staff Signature: _____

LIFEWAYS HELPING PEOPLE

702 Sunset Drive, Ontario, Oregon 97914 *Telephone: (541) 889-9167*
Fax: (541) 889-7873

AUTHORIZATION TO DISCLOSE, RECEIVE AND USE PROTECTED HEALTH INFORMATION

Name: _____ (Last Name), _____ (First Name), _____ (Middle Name)

Date of Birth: _____/_____/_____ Social Security Number: _____-____-_____

RECIPIENT (Person or agency to and/or from whom Lifeways may receive and/or disclosed my protected health information)

Name of Person or Agency:

Address of Person or Agency:

TYPE OF INFORMATION

By checking and initialing any of the lines below, I specifically authorize the disclosure, receipt and use of the type of protected health information I have checked and initialed.

☐ ____ Mental Health Assessment
☐ ____ Mental Health Progress Notes
☐ ____ Mental Health Discharge Summary
☐ ____ Psychiatric Assessment
☐ ____ Psychiatric Progress Notes
☐ ____ Information about Sexual Assault
☐ ____ Information about Child Abuse and Neglect
☐ ____ Educational Records
☐ ____ General Medical Records
☐ ____ Other: _____
☐ ____ Other: _____

☐ ____ Substance Abuse Assessment
☐ ____ Substance Abuse Progress Notes
☐ ____ Substance Abuse Discharge Summary
☐ ____ Developmental Disability Assessment
☐ ____ Developmental Disability Progress Notes
☐ ____ Information about sexually transmitted diseases
☐ ____ Information Necessary to Arrange Transportation
☐ ____ Information Necessary to Deal with an Emergency
☐ ____ Information about HIV/AIDS-related Testing (Including the fact that an HIV test was ordered or reported, regardless of whether the results of such tests were positive or negative)

TERM OF THIS AUTHORIZATION

By initialing one of the lines below, I specifically authorize disclosure, receipt and use of the type of information indicated above by my initials for the term I have checked and initialed below. I understand that I can revoke this authorization at any time by notifying Lifeways in writing of the revocation. I understand that revoking this authorization will not affect information that has already been disclosed, received or used by Lifeways and/or the party or parties from or to whom it was received or disclosed.

This authorization will remain in effect:

☐ ____ for one year from the date of this authorization.
☐ ____ from the date of this authorization until _____
☐ ____ until the following event occurs: _____
☐ ____ other: _____

PURPOSE OF THE AUTHORIZATION

The protected health information covered by this authorization may be used for the purposes I have checked and initialed below:

☐ ____ To assess eligibility and need for treatment
☐ ____ To plan and coordinate treatment
☐ ____ Other: _____

I am:

☐ the person whose protected health information is covered by this authorization.
☐ the parent of the minor child whose protected health information is covered by this authorization.
☐ the legal guardian or custodian of the person whose protected health information is covered by this authorization.
☐ authorized to sign by a currently valid health care power of attorney.

I have read and understand the terms of this Authorization to Disclose, Receive and Use Protected Health Information. By my signature below, I voluntarily authorize disclosure, receipt and use of my protected health information as indicated above. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure and will no longer be protected under federal law. I can revoke it at any time by notifying Lifeways in writing. Refusal to sign the authorization will not adversely affect your ability to receive services or reimbursement for services.

_____ Printed Name of Authorizing Person
_____ Signature of Authorizing Person
_____ Date Signed

_____ Printed Name of Witness
_____ Signature of Witness
_____ Date Signed