AUTHORIZATION TO RELEASE AND EXCHANGE CONFIDENTIAL INFORMATION

You must complete ONE form per person or entity

1. I authorize Lauren Mac Neill, JD, MSW, LCSW to exchange (both receive and share) information regarding (check all that apply):

____Me: (print name):_____

____My minor child/ren or legal dependent(s) (print name(s)):_____

2. With: _____

Name of ONE person and/or entity (per form) and TYPE (eg: attorney, other current or prior therapists that I or my minor child or legal dependents have worked with, including primary care medical provider, other current or prior mental health therapists, health insurance provider, psychiatrist or PMHNP, custody evaluator, psychological evaluator, parent coordinator, parenting time supervisor, DHS, tax advisor, property appraiser, CDFA, other.)

Provider's contact phone and email:_____

3. Including the following types of information: *(check and initial all that apply for this provider)*

___All Medical Records*
___Physical health care information (e.g. medical records, notes, evaluations, labs, prescriptions, hospitalizations, referrals, drug and alcohol information*, HIV information*)
___Legal information (e.g. civil and criminal charges, convictions, filings, case plan, progress of case, general impressions and information)
___Financial information (e.g. asset information, budget information, credit and debt information)
___Other: (specific conditions, limitations on information disclosed, or time periods for information to be released)_____

**If part of the information to be released includes HIV, alcohol and drug, mental health and/or genetic testing information, you must specifically initial the corresponding section in order to comply with federal and state regulations.*

I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information:

___Mental health information (e.g., psychotherapy notes, initial evaluation, diagnoses, symptoms, treatment plan and progress, assessment reports, testing or evaluation data, closing or discharge evaluations or summaries, referrals, general impressions and information)
___Drug/alcohol information (e.g. diagnosis, symptoms, treatment plan and progress, referrals, general impressions and information)
___Genetic testing Information

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4. For the purpose of: *(check all that apply)*

____Assessment
____Treatment
____Case coordination
____Insurance purposes (authorization for treatment, billing, coordination of benefits, quality improvement and/or utilization review)
____Other specific purpose: (describe)_____

5. I understand that this information may be transmitted via photo-copied records, fax, telephone, or other electronic means; and/or verbal communication unless noted otherwise:_____

6. I may revoke this authorization in writing at any time by sending a written statement to Lauren Mac Neill at 3310 SE Division St., Portland, OR 97202 and state that you are revoking this authorization.

I have read this authorization and I understand it. Unless revoked, this authorization expires: (check one):

____At the completion of my case or treatment.
____Other date or event:_____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I understand that I do not need to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

If I am signing this form on behalf of my minor child/ren or legal ward, I affirm that I have the legal authority to do so.

7. Signature(s)

Client (or Personal Representative if applicable):_____

Date: _____

Description of personal representative's authority:_____

Release Revoked: Date:_____ Initials:_____

Lauren M. Mac Neill, JD, MSW, LCSW
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503-380-8528