ROSE CITY
GEROPSYCHOLOGY, LLC

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: _____ **DOB:** _____

I authorize my clinician to: (initial all that apply)
_____ Receive a copy of my specific health information from the person(s) named below
_____ Send a copy of my specific health information to the person(s) named below

To/From: _____

(*Name, address and phone number of person who will send or receive information*)

I authorize this information to be used for: (initial all that apply)
_____ Continuation of mental health care
_____ Coordination with medical providers
_____ Legal issues (*specify*) _____
_____ Other (*specify*) _____
_____ Coordination with education services
_____ Completion of evaluation

I authorize the exchange of the following information: (initial all that apply)
_____Mental health session notes
_____Mental health treatment summary
_____Psychological evaluation reports
_____Other (*specify*) _____
_____Other medical records (*specify*) _____
_____ Billing records
_____ School records

I understand that any information that is exchanged with another person will be protected if that person is required to comply with the Federal Privacy rule. If privacy laws do not apply, the information may not be protected and could be re-disclosed without authorization.

I understand that I may refuse to sign this authorization. My refusal to sign will not prevent me from receiving mental health services or reimbursement for services. The only exception is if the services are solely for the purpose of providing information to someone else and this authorization is necessary to make that disclosure.

I understand that I may revoke this authorization at any time. If I revoke this authorization, it is no longer valid. The only exception is when the authorization was obtained as a condition of obtaining insurance coverage. However, any information exchanged before I revoke this authorization cannot be retrieved. To revoke this authorization, please send a written statement revoking the authorization to: Rose City Geropsychology, LLC, P.O. Box 86816, Portland, OR 97286-0816.

Unless revoked, this authorization will expire in: (initial one)
_____One year
_____Other (*indicate expiration date or event*): _____
_____On termination of mental health treatment

I have read this authorization and I understand it. This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

Signature of Client or Client's Representative: _____ **Date:** _____

Description of representative's authority: _____