RELEASE OF INFORMATION CONSENT

CLIENT'S NAME: _____

CLIENT'S ADDRESS: _____
_____
_____

CLIENT'S TELEPHONE: _____

CLIENT'S EMAIL: _____

I am the client named above. I authorize PATRICK HYLAND, COUNSELOR, located at 207 E. 5th Avenue, Suite 257, Eugene, Oregon 97401, to release/receive (circle one) the following information:

- MENTAL HEALTH COUNSELING HISTORY, DIAGNOSIS, TREATMENT PLAN(S), PROGRESS OR TREATMENT NOTES, INFORMATIONAL LETTER, SUMMARY, OR REFERRAL,

to me, the above-named client, and/or/from (circle or delete) the following named Physician, Psychiatrist, Psychologist, Mental Health Counselor, or other healthcare provider:

NAME/AGENCY: _____

CONTACT INFORMATION: _____
_____
_____
_____

The above-shown information will be used for the following purpose(s*)(circle all appropriate responses)*:

- Planning appropriate treatment or program;
- Continuing appropriate treatment or program;
- Determining eligibility for benefits or program;
- Case Review;
- Updating Files;
- Other: _____

I consent to sharing the information provided for herein.

CLIENT'S SIGNATURE: _____ DATE OF SIGNATURE: _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

CLIENT'S SIGNATURE: _____

DATE OF SIGNATURE: _____

WITNESS SIGNATURE (If client is unable to sign):

WITNESS SIGNATURE:_____

WITNESS DATE: _____