HOOD RIVER COUNSELING, PC
BRIAN WOLFF, LCSW, CADC-III
704 Columbia St, Hood River, OR 97031
(541) 490-7399 (503) 914-6678 fax

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

CLIENT NAME:_____ DATE OF BIRTH:_____

For the above-named client, Brian Wolff and Hood River Counseling, PC is authorized to: Release and Exchange Information with:

NAME/ AGENCY	ADDRESS	PHONE/FAX#

THE HEALTH INFORMATION THAT IS SUBJECT TO THIS AUTHORIZATION PERTAINS TO:
☐ Myself ☐ My child _____ ☐ Other _____

AND INCLUDES THE FOLLOWING*: (Please initial the following)*
_____Mental health and/or substance abuse treatment including: assessment, progress notes, appointment dates & times, referral information, medical records and other clinical records pertaining to treatment.

FOR THE PURPOSE OF:
_____Verification of insurance eligibility, Coordinating or planning for treatment, care, or services, referral to addition providers and other: _____

TERM:
This authorization will remain in effect from the date this authorization was signed OR until the following event occurs or condition exists: _____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as stated above. The revocation may be verbal if I am a client in the Alcohol and Drug Treatment Program, and must be in writing if I am enrolled in a Mental Health Services Program.

I understand that any information regarding participation in an Alcohol and Drug treatment program at Hood River Counseling PC is protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally prosecute any alcohol or drug abuse patient.

I understand that all of my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, though Hood River Counseling PC cannot guarantee that this individual/agency will not re-disclose my health information to a third party. The third party may not be required to abide by applicable federal and state law governing the use and disclosure of my health information; thus, my health information may no longer be protected by HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure.

I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize: Brian Wolff, LCSW and Hood River Counseling, PC to use or disclose health information in the manner described above.

_____ _____/_____/_____ _____
Signature Date Signature of Witness

If individual is 13 years or younger or is otherwise unable to sign this Authorization, please complete the information below:

_____ _____/_____/_____ _____
Signature of Authorizing Individual Date Witness

Relationship to Client:
☐ Parent ☐ Guardian ☐ Authorized health care representative ☐ Health care power of attorney