Jessica Conwell, PsyD

Licensed Psychologist

Authorization for Release of Confidential Information

Client: ____ Date of Birth: ________________

I authorize Dr. Jessica Conwell to _____ Release and/or _____ Receive information from:

____

Person/Organization

____ ______________________

Address Phone Number

This information disclosure will be used for the purpose of: ____________________________________

By initialing the spaces below, I specifically authorize the release of the following medical/mental health records:

Information to be released:	YES	NO
Social, medical, or psychological reports	________	________
Medications used in treatment	________	________
Treatment goals and results	________	________
Information about drug and/or alcohol use	________	________
Court or probation records	________	________
HIV/AIDS related records	________	________
Other (please specify): ______________________________	________	________

I understand that I have the right to refuse to sign this Authorization and that services or treatment cannot be denied to me by Dr. Conwell if I refuse to sign this form. I understand that I have the right to review the health information to be disclosed by this authorization and may request a copy of this authorization.

I understand that this information may be shared via phone, fax, in writing, or in person. The information to be shared will be the minimum amount necessary to accomplish the purpose of this authorization. I understand that the information disclosed under this authorization may be subject to redisclosure and no longer be protected under federal privacy law. However, I also understand that federal or state law may prohibit the redisclosure of alcohol and/or drug treatment information or HIV/AIDS information.

I understand that I have the right to revoke this authorization in writing at anytime; however any disclosures that have already been made with my permission cannot be undone.

I have reviewed this authorization and I understand it. This authorization will be effective beginning on the date it is signed and will expire in 180 days, unless revoked earlier.

____ ________________

Signature of Client Date

____ ________________

Signature of Parent/Guardian (If applicable) Date

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR, Part 2) prohibits you from making further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal regulation also restricts any use of the information to criminally investigate or prosecute the patient.

Professional Corporation • 15350 SW Sequoia Parkway Suite 105 • Portland, OR 97224 • (503) 789-9377 • (503) 431-2126 *fax*