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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, ★_____ [client's name] ★_____ [client's date of birth],
give permission to Sheryl Moren, PMHNP-BC, LLC, 2025 SE Jefferson St. #6, Milwaukie, OR 97222, to **(initial)**:

_____ Disclose/send records to: Name(s)/Specialty:★_____
_____ Exchange health information with: Agency:★ _____
_____ Receive health records from: Address: _____
City, State, & Zip Code: _____
Phone: _____ Fax: ★_____

This protected health information is being used or disclosed for the following purposes **(initial by all that apply)**:

_____ Continuation of mental health care _____ Insurance claim
_____ Coordination of care _____ Other (specify): _____

To include **(initial all that apply)**:

_____ All information in chart _____ Specific chart information: _____

Health information to be disclosed **(initial by all that apply):**

_____ Mental health records _____ Genetic testing information
_____ Medical records _____ HIV/AIDS related records
_____ Laboratory reports _____ Drug/alcohol diagnosis, treatment, or referral information
_____ Other (specify): _____

The scope of information authorized for release involves records covers **(initial by all that apply):**

_____ All dates of service _____ Service between _____ and _____

Unless revoked, this authorization expires:

_____ in one year _____ on _____(MM/DD/YYYY)
_____ upon termination of services _____ 3 months after termination of services

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 at any time. 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 If I revoke this authorization, it is no longer valid.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 this authorization to: Sheryl Moren, PMHNP-BC, LLC at 4207 SE Woodstock Blvd #286, Portland, OR 97206.

I may inspect or copy any information used and/or disclosed under this authorization. Sheryl Moren, PMHNP-BC, LLC, an independent practitioner, is not responsible for the cost of copies.

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 Date Signature of Witness Date

★_____ _____
Printed Name of Participant (or Personal Representative) Description of Personal Representative's Authority