Christine Wilkes, Psy.D.
Licensed Psychologist
2100 NE Broadway Street, Suite 331, Portland, OR 97232

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(This authorization must be written, dated and signed by the client or by a person authorized by law to give authorization.)

CLIENT NAME: _____ DOB: _____

I authorize Christine Wilkes, Psy.D. to: __ release information to and/or**__ receive information from:**

_____

(Person/Organization) (Address) (Telephone number)

While I am/was a client of the above during: Evaluation

Information will be used on my behalf for the following purpose(s): Coordination of services

By **checking** the relevant spaces below, I specifically authorize the release of the following mental health or medical records, if such records exist:

____ Medical Records
____ Medications used in treatment
____ School reports
____ Psychological reports
____ Psychiatric reports
____ Treatment goals/progress

_____ Mental Health Records
_____ HIV/AIDS Records**
_____ Information about drug and/or alcohol use *
(specify)_____
_____ Laboratory Reports
____ Other (specify) _____

* Federal Regulation, 42 CFR Part 2, requires a description of drug/alcohol information to be disclosed.
** HIV/AIDS information must be initialed to be included in other documents.

I understand that I may revoke this authorization either in writing or verbally at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. Any use or disclosure already made with my permission cannot be undone. I understand that this information may be shared via phone, fax, written, email or in person. The information being shared will be the minimum amount necessary to accomplish the purpose of this authorization. If not revoked before, this authorization will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed and no longer protected under federal law. However, I also understand that federal or state law (ORS.179.505) may restrict redisclosure of information about: HIV/AIDS, mental health, genetic testing, drug/alcohol diagnosis, and treatment or referral.

I have carefully read and understand this authorization for release of protected mental health and medical records and I voluntarily authorize disclosure of these specified records for the purposes stated above.

_____ _____
Signature of client Date

_____ _____
Parent/legal guardian signature Date

_____ _____
Witness signature Date