Authorization to Use and Disclose Protected Health Information

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Clackamas, Oregon 97015
Phone: (503) 941-0245 Fax: (503) 972-1658

Client Name: _____ DOB: _____/_____/_____

With my signature below, I authorize **Dr. James Mours** to:

☐ OBTAIN information from ☐ Disclose information to

Contact Person: _____ Organization: _____

Address: _____ Telephone: _____

City, State, Zip: _____ Fax: _____

Information to be used/disclosed consists of mental healthcare information, including:

☐ Assessment or Evaluation ☐ Treatment Plan ☐ Notes ☐ Coordination of care information
☐ Other: _____

The purpose for the disclosure/communication:
☐ Coordination of care ☐ Other: _____

I understand that additional *laws* about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space.

Initial: _____ Mental health information
Initial: _____ Drug/alcohol diagnosis, treatment, or referral information
Initial: _____ HIV/AIOS information
Initial: _____ Genetic testing information

Other information
I understand that I am not required to sign this authorization. If I refuse to sign this, it will not prevent me from getting mental health or drug/alcohol treatment with Dr. James Mours. The only exception is if the services I am seeking are only for providing health information to someone *else* and this authorization is needed to make the disclosure.
I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reasons described here. If Dr. James Mours has already used or disclosed information, that disclosure or use cannot be undone.
I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/A/DS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization expires 60 days after the completion of treatment or: _____

Signature
I have read this authorization and understand it.

Client Signature: _____ Date: _____

Parent/Guardian/Representative signature: _____ Date: _____

If personal rep, print name: _____
Relationship to client: ☐ Parent ☐ Legal guardian ☐ Power of Attorney/Healthcare ☐ Other: _____