A Better Way Counseling Center
818 NW 17th Avenue, Suite 3
Portland, Oregon 97209
(503) 226-9061

Authorization to Disclose Protected Health Information

I hereby authorize the staff of A Better Way Counseling Center to disclose to
_____
_____
Phone: (____)_____ (Recipient)
the following protected health information regarding _____ (Client):

Yes____ No____ Entire File
Yes____ No____ Psychotherapy Notes
Yes____ No____ Session Start/Stop Times
Yes____ No____ Dates of Treatment
Yes____ No____ Diagnosis
Yes____ No____ Symptoms
Yes____ No____ Progress to Date
Yes____ No____ Clinical Test Results
Yes____ No____ Prognosis
Yes____ No____ Treatment Plan
Yes____ No____ Modalities of Treatment Furnished
Yes____ No____ Employment/Unemployment
Yes____ No____ Educational Reports
Yes____ No____ Alcohol/Drug Treatment
Yes____ No____ Mental Health Services
Yes____ No____ Medical/Psychiatric Treatment
Yes____ No____ Legal History
Yes____ No____Finances
Yes____ No____Family and Living Situation History
Yes____No____Other_____
_____

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless A Better Way Counseling Center has taken action in reliance upon it. I also understand that such revocation must be in writing and received by A Better Way Counseling Center to be effective.

I authorize the disclosure of the health information described above for the following purpose:
___ Treatment coordination
___ Other: _____

The specific uses and limitations on the uses of my health information by Recipient are as follows:
___ Treatment Coordination
___ Other: _____
_____

The specific uses and limitations on the types of information to be released are as

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follows:
___ Treatment Coordination
___ Other: _____
_____

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable Oregon law.

A Better Way Counseling Center is authorized to disclose the protected health information specifically listed above until:
_____(authorization expiration date)

Signature _____ Date ____/____/_____
Parent or Guardian _____ Date ____/____/_____
Witness _____Date ____/____/_____

*If signed by any person other than Patient, please indicate the relationship between Patient and his/her Representative:

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

This is a true copy of the original authorization document _____(Staff Person)