Laurel Hill Center

2145 Centennial Plaza
Eugene, OR 97401
Phone: (541) 485-6340 & Fax: (541) 984-3124

Authorization to Use and Disclose Confidential Health Information
Release of Information

Agency/Contact Name:____________________________Contact Information: __________________________

Participant Name:_____________________________DOB:______________Phone #: _____________________

Purpose of Disclosure: ☐ Continuity of Care and/Or Coordination of Services:

☐ MH Assessments/Evaluations ☐ Medication/Prescriptions ☐ Discharge Summaries ☐ Progress Notes
☐ Treatment/Service/Care Plan ☐ Lab Reports ☐ Physical Health Records ☐ Account Information

Other: ____

Mutual Exchange of Records**:** ☐ Yes ☐ No

Protected Information to be Released - Please Initial Individually (records cannot be released without initials):

_____ Mental Health Psychotherapy _____ Drug/Alcohol Treatment Records
_____ HIV/AIDS Treatment Records _____ Genetic Testing Records

This release authorizes the agency or individual identified above to exchange information, provide information to, or receive information from Laurel Hill Center to assist with support and services.

I understand that I may choose not to sign this authorization and that my choice not to sign will not affect my ability to receive services. I understand that I can revoke this authorization in writing at any time; however, any such revocation will not apply to any activity previously undertaken based on this authorization. I understand that state and federal privacy laws protect the re-disclosure of mental health treatment records, Drug and Alcohol diagnosis, treatment and records and HIV/AIDS/ sexually transmitted disease without my written authorization or under specific situations allowed under the law to agencies or individuals who are legally required to keep it confidential. I understand if I have authorized the disclosure of my health information to someone who is not legally required to keep this information confidential, it may be re-disclosed and is no longer protected.

Authorization beginning date ___________ and ends _________ **OR** ☐ at the conclusion of services.

I have read this authorization and understand it.

______________________________________ ______________________________________
Signature of person authorizing release Date Signature of legal/personal representative Date

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Signature of Laurel Hill Center Staff Date