madrona recovery

Client Name _____
Date of Birth _____

Authorization to Release Clinical Record Information

This authorization must be written, dated, and signed by a person authorized by law to give this authorization.

I Authorize:

☐ **Madrona Recovery OR**
7000 SW Varns St.
Tigard, OR 97223
Phone: (503)749-0200
Fax: (503)746-5906

☐ **Madrona Recovery WA**
11910 NE 154th St
Brush Prairie, WA 98606
Phone: (360)-822-3400
Fax: (360)-828-7281

☐ **Madrona Recovery OR Outpatient**
6960 SW Varns St.
Tigard, OR 97223
Phone: (503)749-0200
Fax: (503)746-5906

To provide/ obtain/ exchange information from the clinical record for the above-named client to/ from/ with:

_____
(Name of Person/Facility/Agency) (Relationship to Client)

_____
(Address) (City) (State) (Zip)

Phone _____ Fax _____

By initialing the spaces below, I specifically authorize the release of the information, if such information exists:
_____ Mental Health diagnosis, treatment or referral information _____ HIV/AIDS related records
_____ Drug/alcohol diagnosis, treatment or referral information

The following information will be released/exchanged:
❒ Discharge Summary ❒ History & Physical ❒ Consultations and Assessments ❒Medications
❒ Psychiatric Evaluation ❒ Laboratory Reports ❒ Treatment Plan ❒ Psychotherapy notes
Other _____

The information will be released for the following purposes:
❒ to facilitate treatment and continuity of care ❒ to facilitate billing and reimbursement
❒ request by parent/legal guardian ❒ other (specify) _____
❒ This authorization is limited to information about the following treatment:

_____

☐ This authorization is limited to information from the following time period: _____

I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, some or all of the information described above may be redisclosed and is no longer protected by those regulations. Federal or state law may restrict redisclosure of HIV/AIDS test or result information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information. I release Madrona Recovery, its physicians, its business associates, and its employees from all liability arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. This authorization may be revoked at any time by notifying the Medical Records Department (orally or in writing at the above phone number and address) knowing that information already disclosed cannot be revoked.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company or is necessary to determine if I am eligible to enroll in the health plan.

_____ _____ _____ _____
Client Signature Date Staff Signature Date

_____ _____
Parent/Legal Guardian Date