The Counseling Hut

PO Box 50113, Eugene, OR 97401
541-342-8144 (Phone/TTY) 541-342-1724 (Fax)
http://www.thecounselinghut.org/

Authorization for Release of Information

Revised July 1, 2011

Client Name: _____ Date of Birth: ____/____/____

Provider: _____

Address: _____

Authorization (Please select one):

_____ I authorize the Counseling Hut to provide me with the following information pertaining to my care. I understand that I assume full responsibility for protecting the confidentiality of the information I receive.

_____ I authorize the Counseling Hut and the provider specified above to exchange any information necessary and useful for coordinating my care.

_____ I authorize the Counseling Hut to forward the following information to the provider specified above.

_____ I authorize the provider specified above to forward the following information to the Counseling Hut.

Information to be included (Please Initial):

_____ Mental Health Assessments _____ Mental Health Progress Notes _____ Medications

_____ Substance Use History _____ Other: _____

Time Limit (Please select one):

_____ Please include all information available as of: ____/____/____

_____ Please include all information from: ____/____/____ to: ____/____/____

_____ Please continue to exchange information until: ____/____/____

_____ Please continue to exchange information for one year from today.

I understand that the information will be exchanged in person, by phone, by fax, or by USPS first class mail, using the method which the Counseling Hut and the provider deem to be appropriate and to be best for protecting my privacy. I understand that the Counseling Hut or the provider may choose not to provide the information I requested according to best clinical judgment, in order to protect my privacy, or if doing so is potentially harmful to me.

_____ _____

Client or Client's Representative Date Client or Client's Representative Date