The Northwest Catholic Counseling Center

Phone 503-253-0964 * Fax 503-253-7659

File #_____

Authorization for Release of Information

Name:_____ DOB: _____

I authorize an exchange of confidential information between the Northwest Catholic Counseling Center ("NWCC") and:

Dr/Provider Name:_____

Address:_____

Phone: _____ Fax: _____

Please provide the following information or records (*you must initial those requested*):

_____Family History	_____Education Report	_____ Test results
_____Mental Health Services	_____Clinician Chart Notes	_____ Other
_____Alcohol/Drug Treatment	_____Medical Records	
_____Treatment Plan	_____HIV/AIDS Records	

Purpose of Exchange:_____

_____

The information disclosed will be used to coordinate services. My treatment by NWCC may not be conditioned upon my agreement to sign this Authorization. This Authorization will be in effect for one year from the date I sign it. I may revoke the Authorization in writing at any time, but I understand that a revocation will not affect any information released before the revocation.

I understand that if the person or agency receiving my health information from NWCC is not covered by federal or state privacy laws, the released information may no longer be protected.

I have read and I understand the terms of this Authorization, and I have had an opportunity to ask questions about the use and exchange of my health information. By signing below, I knowingly and voluntarily consent to the disclosure and exchange of information described in this Authorization.

_____ _____

Typed name of client valid as signature Date

_____ _____

Typed name of Parent/Legal Guardian valid as signature Date

To those receiving information under this Authorization:

This information 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.

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