Stephanie C. Evans, PsyD Clinical Psychologist

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ACCORDING TO ORS 192.520

I, _____(Patient's name/Consenting Adult/Patient Representative)
authorize mutual exchange of protected health information from my clinical record between
Stephanie C. Evans, PsyD Clinical Psychologist and

Name: _____

Mailing Address: _____

Phone: _____**Fax**: _____

I authorize and request the mutual exchange of this specific information:
_____ **AT MY REQUEST** _____ **AT MY REQUEST FOR MY CHILD** _____
(Patient's name)

PATIENT'S DOB: _____

Please initial next to each line of protected health information that you authorize disclosure of.

_____/_____**ALL RECORDS**, including:
_____/_____**HIV/AIDS** information
_____/_____**MENTAL HEALTH** information
_____/_____**GENETIC TESTING** information
_____/_____**DRUG/ALCOHOL DIAGNOSIS, TREATMENT OR REFERRAL**
_____/_____**OTHER** _____

For the purpose of:

Please initial next to each one that applies.

_____/_____**AT MY REQUEST**
_____/_____**AT MY REQUEST FOR MY CHILD**
_____/_____**COORDINATION OF CARE AND TREATMENT**
_____/_____**PSYCHOLOGICAL/ NEUROPSYCHOLOGICAL TESTING/ ASSESSMENT**

This authorization will remain in effect until:
_____**DATE** or until revoked.

This authorization may be revoked in writing at any time. If this authorization is revoked, the information listed above will no longer be used or disclosed for the purposes described in this written authorization.

I understand that once information leaves this office, it is the responsibility of the recipient to protect the information according to the **ORS 192.520** and the **Health Insurance Portability and Accountability Act of 1996**.

By signing this form, I have read this authorization and understand it.

SIGNATURE OF PATIENT (*If over 14 years old):* _____ **DATE**: _____

SIGNATURE OF PARENT/REP.: _____ **DATE**:_____

_____

Representative Authority: _____

SIGNATURE OF WITNESS: _____ **DATE**: _____