

### Consent to Release and Receive Protected Health Information

CLIENT: \_\_\_\_\_

DOB: \_\_\_\_\_

I hereby authorize and provide permission to the provider/individual listed below

- to release information to
- to receive information from
- to exchange information with

1.	Name:	Drew Culver
2.	Agency:	Parrott Creek Child & Family Services
3.	Address:	1001 Molalla Avenue Suite 209
		Oregon City OR 97045
4.	Phone:	503-722-4110
5.	Fax:	503-655-8908

I give permission to the providers/individuals listed above to exchange my information in the following ways:

- Via discussion    
  via facsimile    
  via mail    
  via e-mail

#### PURPOSE OF DISCLOSURE Please check all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> Assessment/Treatment/Coordination of Care    | <input type="checkbox"/> Housing                      |
| <input checked="" type="checkbox"/> Program Eligibility Determination | <input type="checkbox"/> At the request of the client |
| <input type="checkbox"/> Court/Legal/Corrections                      | <input type="checkbox"/> Other:                       |

#### TYPE OF INFORMATION TO BE RELEASED

By **INITIALING** below, I specifically give permission to release my following records.

- |                                 |   |
|---------------------------------|---|
| * _____ Assessments/Evaluations | _____ Treatment/Service Plans           |
| _____ Progress Notes            | _____ Psychiatric/Psychological Testing |
| _____ Current Mental Status     | _____ Academic Records/Progress         |
| * _____ Medication Records      | * _____ Laboratory Report               |
| _____ Entire Record             | _____ Housing/Lease Information         |
| _____ Other (specify) _____     |   |

1. Counselor Name
2. Outpatient Treatment Name
3. Full address: City / State / Zip Code
4. Main phone #
5. Fax # (if available)

\* Initials required for these records

I give permission to release my records from the following dates:

1. \_\_\_\_\_ To \_\_\_\_\_

I understand I can revoke this consent at any time. However, my withdrawal of this consent is not retroactive to any action already taken. This consent, unless expressly revoked earlier, expires on:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ The end of services  
Date Event or Condition

**Information regarding re-disclosure of your health information:** Be aware if you provide us permission to share your information with others, they may share that information without your permission. In some instances federal and state law may protect your information from being shared by others if it is mental health information, genetic information or drug/alcohol diagnosis, treatment, or referral information.

**Information regarding your treatment, payment for treatment, enrollment in a health plan or eligibility for benefits:** If another provider requests Parrott Creek Child & Family Services to provide services to you and you do not give us your written permission to release your information to them, we may not be able to provide you with that service.

\_\_\_\_\_  
Client Signature 2. \_\_\_\_\_  
Date

- 1. Today's date through one year later (i.e. 1/1/2023 to 1/1/2024)
- 2. Today's date