GREAT CIRCLE
RECOVERY

Release of Information

FAX TO: 503-983-9899

Patient Name: _____ ID: _____ Date: _____

Date of Birth: ___/___/_____ Clinic: _____

I, _____, do authorize the above named clinic to disclose and/or request from:

Name _____ Email _____

Address _____

City _____ State _____ ZIP _____

Data to be released:

❏ Clinical Evaluation ❏ Diagnosis ❏ Treatment Plan/PCP ❏ Presence/Participation in Tx
❏ Collection of fees/payment ❏ Screening/Referral Information ❏ Discharge/Transfer Summary
❏ Psychiatric/Psychology Evaluation ❏ Progress Notes ❏ Substance Abuse and Related Info
❏ Medication History/Physician Orders ❏ Urine Drug Screen/Oral Swab Results ❏ HIV, AIDS, or AIDS Related Info
❏ Safety Issues and Concerns Related to Program Absence
❏ Dates of Service, Types of Services, Service Providers, Time Billed
❏ Labs and Special Test: _____
❏ Other Evaluations/Assessments: _____
❏ Other: _____

Info to be released:

❏ To provide ongoing treatment and/or aftercare
❏ To coordinate treatment with a family member or concerned other
❏ To coordinate treatment with another provider and/or agency
❏ To provide information to a third party or other funding source

I understand information regarding substance abuse diagnosis and/or treatment may be included if applicable, and if I consent. In accordance with the doctrine of informed consent I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not prohibit the recipient from redisclosing it. When this agency discloses mental health and developmental disabilities or substance abuse related information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information and that redisclosure is prohibited except as permitted or required by this law. I hereby acknowledge that this consent is truly voluntary and shall expire twelve (12) months from the date below and must be reauthorized at that time unless specified sooner in following line (not to exceed one year). I understand that I may refuse to sign this authorization form. If I choose not to sign this form, I understand that this agency cannot deny or refuse to provide treatment on my refusal to sign, but I (or designated legal representative) shall be responsible for full payment for services rendered. I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing with the issuing medical facility.

_____ _____
Signature Date