SEQUOIA
MENTAL HEALTH SERVICES, INC.

Acknowledgment of Notice of Privacy Consent
Release of Information Authorization

Name: _____ Date: _____

By signing below, I hereby acknowledge receipt of Sequoia Mental Health Services' Notice of Privacy Practices.

By signing below, I consent to the use and disclosure of health information about me in order that Sequoia Mental Health Services and its employees and contractors may provide treatment to me, obtain payment (for the treatment) from my third party payers (e.g. the Oregon Medicaid program or my HMO) and carry out their health care operations.

I specifically authorize their use and disclosure of my health information about treatment of mental illness, and substance use diagnosis, treatment, and referral information, for billing, payment, utilization management, and care coordination purposes.

I understand that this information may be released to the following entities:

- ○ **Washington Co. Behavioral Health**
- ○ **Multnomah Co. Behavioral Health**
- ○ **Clackamas Co. Behavioral Health**
- ○ **HealthShare of Oregon**
- ○ **Performance Health Technology**
- ○ **State of Oregon**
- ○ **Care Oregon**
- ○ **Tuality Healthcare**
- ○ **Medicare**
- ○ **Providence**

I understand that this consent to release information **expires upon discharge** and that I may revoke this consent prior to that time except to the extent to which Sequoia Mental Health Services has taken action in reliance upon this consent. However, I also understand that no revocation of this consent is valid with respect to inspection of records necessary to validate expenditures on behalf of governmental entities.

_____ _____
Signature of Client (or Personal Representative) Date of Signature

Refusal to Sign:

The above named client has received this notice but has refused to sign.

_____ _____
Sequoia Mental Health Services Staff Date