SEQUOIA
MENTAL HEALTH SERVICES, INC.
4585 SW 185th Ave. Aloha, OR 97078 Phone: 503-591-9280 Fax 503-848-2072

AUTHORIZATION FOR EXCHANGE / RELEASE OF INFORMATION

Client Name: ____ **DOB:** _________________________________

I authorize Sequoia Mental Health Services to mutually exchange information with:

____

Agency

____

Name Address Phone

The following information may be released:

- ☐ Psychiatric/Mental Health
- ☐ Physical Health
- ☐ Lab Reports
- ☐ Urinalysis (Including Substance Use Info)
- ☐ Medication Information
- ☐ History and Assessments
- ☐ Progress Notes
- ☐ Financial
- ☐ Legal
- ☐ Discharge Summary
- ☐ Other: ________________

Special Release Disclosures **MUST BE INITIALED:**

______ HIV/AIDS Status

______ Substance use diagnosis, treatment or referral

*****Information may include Substance Use Disorder Diagnosis, Treatment, and Referral Information.*****

Purpose of disclosure:

☐ Care coordination ☐ At the request of the client ☐ Other: _________________________

This authorization will remain in effect until:

☐ 1 year from today's date ☐ 30 Days after discharge ☐ Other: _________________________

I understand that my mental health records are protected under federal confidentiality regulations (Health Insurance Portability and Accountability Act of 1996). I understand that substance use disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability Act of 1996. These records cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance of this release, and that in any event, this release expires automatically one year from execution date below. You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

Date: ____________________

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR, Part 2 prohibits you from further disclosure without the signed consent of the individual or as otherwise permitted by the regulations. Sequoia Mental Health Services cannot be responsible for further re-disclosure of information given to another party. This disclosure is not protected by the Privacy Rule.

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Signature of Client

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Signature of Witness

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Signature of Parent/Guardian if required