

**OPAL Institute**  
**Oregon Passionate Aging and Living**  
**14780 SW Osprey Dr. #285, Beaverton, OR 97007**  
**Phone: (503) 308-4251 Fax: 503-591-8628**

**AUTHORIZATION TO RELEASE / OBTAIN INFORMATION**

**Client** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Information to be Released/Obtained:**

- Treatment information
- Mental Health Treatment Information
- Other: \_\_\_\_\_  
\_\_\_\_\_

I hereby authorize OPAL Institute, LLC to communicate with the individual(s) or organization(s) listed below in order to coordinate my care, or to arrange appropriate referrals for me. I understand that the details of my treatment, including but not limited to formal diagnoses and lists of medications, may have to be revealed in order for me to have access to appropriate services.

I am aware of the privilege for confidential communication between client and clinician. I understand that the information received or disclosed related to this authorization may be subject to redisclosure and may no longer be protected by federal law. I understand my medical records are protected under applicable state and federal laws governing health care information and under federal regulations. I understand the information obtained about me may be included in any written reports produced as a result of this evaluation. I understand information about me can be released in verbal or written form. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. If I do not revoke this consent, it will expire one year after the date it is signed. To revoke this authorization, provide a written statement that you are revoking this authorization to OPAL Institute, LLC.

I, \_\_\_\_\_, hereby authorize OPAL Institute, LLC to release and/or obtain information to/from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Client/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Date