



OPAL Institute
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: _____ DOB: _____

I authorize provider _____, OPAL Institute
to: (initial all that apply)

- Receive a copy of my specific health information from the person(s) named below
Send a copy of my specific health information to the person(s) named below

To/From: _____

I authorize this information to be used for: (initial all that apply)

- Continuation of mental health care
Coordination with medical providers
Legal issues (specify)
Coordination with education services
Completion of evaluation
Other (specify)

I authorize the exchange of the following information: (initial all that apply)

- Mental health session notes
Mental health treatment summary
Psychological evaluation reports
Other medical records (specify)
Billing records
School records
Other (specify)

I understand that any information that is exchanged with another person will be protected if that person is required to comply with the Federal Privacy rule. If privacy laws do not apply, the information may not be protected and could be re-disclosed without authorization.

I understand that I may refuse to sign this authorization. My refusal to sign will not prevent me from receiving mental health services or reimbursement for services. The only exception is if the services are solely for the purpose of providing information to someone else and this authorization is necessary to make that disclosure.

I understand that I may revoke this authorization at any time. If I revoke this authorization, it is no longer valid. The only exception is when the authorization was obtained as a condition of obtaining insurance coverage. However, any information exchanged before I revoke this authorization cannot be retrieved. To revoke this authorization, please send a written statement revoking the authorization to:

OPAL Institute, PO Box 2280, Portland, OR 97208

Unless revoked, this authorization will expire in: (initial one)

- one year
other (indicate expiration date or event):
on termination of mental health treatment

I have read this authorization and I understand it. This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

Signature of Client or Client's Representative
Description of representative's authority:
Date