WALLOWA VALLEY
CENTER for WELLNESS

AUTHORIZATION TO USE / EXCHANGE INFORMATION

606 Medical Parkway / P.O. Box 268 Enterprise, Oregon 97828 Phone: 541-426-4524 Fax: 541-426-3035

Client's Name: _____
Last First Middle

DOB: _____ Home Phone: _____ Cell: _____

Mailing Address: _____
City State Zip

I authorize the following individual and/or agency to provide or exchange the following information with **WVCW**

_____
Name Phone Fax

_____
Address City State Zip

_____(By initialing here) I AUTHORIZE THIS RELEASE OF INFORMATION TO INCLUDE any information about MENTAL HEALTH

_____

_____

____(By initialing here) I AUTHORIZE THIS RELEASE OF INFORMATION TO INCLUDE any ALCOHOL / DRUG/ GAMBLING DIAGNOSIS TREATMENT, AND PROGNOSIS INFORMATION. I UNDERSTAND THAT ANY DISCLOSURE MADE IS BOUND BY Part 2 of Title 42 of the Code of Federal Regulations (CFR) governing confidentiality of alcohol and drug abuse patient records. **Recipients of this information may re-disclose it only with written consent** or as permitted in 42 CFR Part 2.

____(By initialing here) I AUTHORIZE THIS RELEASE OF INFORMATION TO INCLUDE any HIV / AIDS diagnosis, treatment prognosis information.

The following MUST be complete for all requests for information:

___ Initial here for VERBAL information exchange ONLY

CLIENT: Please INITIAL after "**how much**" and "**what kind/description**" to authorize quantity/type of information to be disclosed.

continue to next page

How much documentation is to be disclosed:

___ Last 6 months ___Last 1 year ___ Last 2 years
___ ALL ___Other:_____

What kind/description of information is to be disclosed:

___Treatment Plan ___Assessment ___Progress Notes/Reports
___Med Orders/Med Notes ___Psychiatric Evaluation ___Lab Work/Test Results
___Discharge Summary ___Other (Specify) _____

Purpose of Disclosure: I authorize WVCW to use/exchange my health information noted above for the **purpose of evaluation, treatment planning, service coordination, monitoring, and treatment referral.** If this authorization is to be used for additional purposes, or purposes other than those noted here please indicate here: ___ **(Initial) ** I understand Wallowa Valley Center for Wellness (WVCW) cannot guarantee information will not be disclosed if the information is released to an organization NOT SUBJECT to Federal and State Laws.****

TERM: I understand that **I may revoke this authorization at any time** except to the extent that action has been taken in reliance upon it. I understand that I may refuse to sign this authorization, and that refusal to sign this authorization may affect WVCW's ability to coordinate and obtain services. Without my expressed revocation, this **Authorization will expire one year from the date of signing** or shall remain in effect for the period I am enrolled in services at WVCW, unless otherwise stated below:

____ This authorization is limited to the time period or until the following event occurs: _____

I have read and understand the terms of this authorization and I have had the opportunity to ask questions about the use and exchange of my health information. By my signature, I hereby, knowingly and voluntarily authorize WVCW to use/exchange my health information in the manner described above.

_____

Signature of client/Authorized Personnel **Date**

_____

Relationship to client