## MARCIA JOHNSTON WOOD, Ph.D.

Clinical Psychologist

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5441 SW Macadam, #104, Portland, OR 97239 Phone (503) 248-4511/ Fax (503) 248-6385

## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

| CLIENT NAME:  | DOB:                   |  |
|---|------------------------|--|
| I authorize Marcia Johnston Wood, Ph.D. to (initial all that apply): receive my specific health information from the person(s) named below provide/send my specific health information to the person(s) named below                                 |                        |  |
| Clinician/Facility Name:  | Phone:                 |  |
| Address:  |                        |  |
| Service or care they provide(d):  |                        |  |
| I authorize this information to be used for (initial all that   | apply):                |  |
| Continuation of mental health care Insurance/ Quality Assurance/ Utilization Review Coordination with medical providers At the request of the individual Legal issues (specify) Other (specify)   |                        |  |
| I authorize the exchange of the following information (in   | itial all that apply): |  |
| <ul> <li>Mental Health Session Notes</li> <li>Billing Records</li> <li>Mental Health Treatment Summary</li> <li>School Records</li> <li>Psychological Evaluation Reports</li> <li>Consultations</li> <li>Other Medical Records (specify)</li> </ul> |                        |  |
| HIV/AIDS-related related records Drug/alcohol diagnoses, treatment or referral information. Other (specify)   |                        |  |

\* Federal Regulation requires a description of how much and what kind of drug/alcohol information is to be disclosed.

You agree to pay all reasonable charges that may be associated with providing the records you request.

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 me at 5441 SW Macadam, suite 104, Portland, OR 97239.

| Unless revoked, this authorization will expire in (initial one   | <b>):</b>                   |                            |
|--|-----------------------------|----------------------------|
| one year on termination of mental health treatment other (indicate expiration date or event):  |                             |                            |
| I have carefully read this authorization and I understand it specified records for the purposes stated above. (This compor a person authorized by law to represent the client. A copy of | oleted authorization must b | pe signed by the client(s) |
| Signature of Client  | Date                        |                            |
| Signature of Client  | Date                        |                            |
| or   |                             |                            |
| Signature of Person Authorized by Law Description of Representative's authority:   |                             |                            |

(Revised 8/11)