HOPE & HARBOR

696 McVey Ave, Ste 204
Lake Oswego, OR 97034
www.hope-harbor.com
503-387-1790

Authorization to Exchange Confidential Information

I, [Name of Patient] _____

Hereby authorize [Name of Provider]_____

To exchange confidential information regarding my treatment with [name and function of the person (s) or entities to which information is to be exchanged]_____

_____

This Authorization permits the exchange of the following information:

____ Assessment/Evaluation
____ Diagnosis
____ Client Intake
____ Therapy Session Notes
____ Current Progress in Treatment Update
____ Medication Management Information
____ Presence/Participation in Treatment
____ Medical Information
____ Educational Information
____ Discharge / Transfer Summary
____ Continuing Care Plan
____ Legal Information

Other _____

_____

I authorize the exchange of the information described above for the following purpose(s):

_____

_____

The recipient may use the information described above solely for the following purpose(s):

_____

_____

I understand that I have a right to receive a copy if this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This authorization shall remain valid until: _____ ("Expiration Date")

Signature: _____ Date: _____
(Client or Client's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her

Representative: _____