Liberty House
375 Taylor Street NE
Salem, OR 97301

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize Liberty House to disclose and exchange mental health information described below regarding:

_____ _____
(Name of Client) (Date of Birth)

To/From: _____
(Please list name and address of recipient)

Consisting of:

Mental Health Information, including but not limited to attendance, treatment goals, session content, and diagnoses _____ Initial: _____

Other: _____ Initial: _____
(Please describe information to be used/disclosed)

For the purposes of: _____
(Please describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose):

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of (1) creating health information about you to be disclosed to a third party; or (2) for the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the Custodian of Records at Liberty House, 2685 4th Street NE, Salem OR 97301, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This authorization will expire on the earlier of either _____ (date) or one year from the date of signing.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Client Signature: _____ Date _____
(if 14 or older)

Parent/Guardian Signature: _____ Date _____

Parent/Guardian Printed Name: _____