Portland DBT Institute, Inc.
5100 S Macadam Ave, Suite 350
Portland, OR 97239
Phone: 503-231-7854
Fax: 503-231-8153

PDBTI Therapist Name:
_____

Please mark as applicable:
_____ PDBTI is **SENDING Records** to Named Party
_____ Keep Release **ON FILE** for Future Use
_____ PDBTI is **REQUESTING Records** from Named Party

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

A. By signing this form, I, (client's full name) _____, authorize **Portland DBT Institute, Inc.** the use and disclosure of my individually identifiable health information to/from:

_____ _____
Name of Person, Organization Represented (if applicable) Relationship to Client

_____
Address of Named Party Phone Number / Fax Number of Named Party

B. Purpose of Disclosure: Mental Health Treatment Planning and Continuity of Care. Health information that may be used or disclosed through this authorization is as follows:

____Assessment/Treatment/Coordination of Care ____Eligibility Determination ____Legal/Court/Corrections/Probation
____At the request of the client ____As needed for Billing/Financial ____Other: _____

C. Specific Information to be Disclosed: By **initialing** next to a category listed below, I specifically authorize use of confidential information: (*Please write your **INITIALS** below by each selected category.*)

_____ Psychiatric and Mental Health information as included in the records
_____ Substance Use Disorder (SUD)/Alcohol and Drug Treatment information (Specifically protected under law), *except for* the following (if no exceptions, leave blank): _____
_____ AIDS/HIV/ other STD testing information (Specifically protected under law)
_____ All health information about me as described above, *excluding* the following: _____
_____ Specific health information including *only*: _____
_____ Mail records certified if indicated by Portland DBT Institute

D. I give permission to release my records from the following dates (*Note*: this is a required section):

_____ _____
(Approximate **start date** of treatment from provider) (Approximate **end date** of treatment from provider)

E. I understand that my records are protected under the federal and state confidentiality regulation, including HIPAA, CFR 42 Part 2, 45 CFR Parts 160 and 164, RCW 71.05, 70.02, 71.34,74.04, 13.50.100(4)(b) and WAC 388-865-0436 or its successor, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time, but that in any event this consent expires automatically in **180 days** or shall remain in effect for the period of time reasonably needed to complete the request. I understand that I may refuse to sign this authorization and that such refusal will not affect my ability to obtain treatment from Portland DBT Institute.

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this authorization.

Date _____ Signature of Client: _____
Client's Full Name (Print): _____
Client's Date of Birth: _____ Client's SS#: _____
Date _____ Signature of Parent/Legal Representative*: _____
*When client is not of legal age or competent to give consent, the signature of Parent or Legal Representative

F. Redisclosure: If you give us permission to share your information with others, they may share your information without your consent. We cannot ensure that your information will be protected by others. However, some instances of State and/or Federal law may protect your information from being shared with others if it is information about HIV/AIDS, mental health, genetics, or drugs/alcohol.

G. Information about treatment, payment, and insurance: If your written permission to release health information about you is needed to determine your eligibility for medical programs and you do not give us permission to release your health information, then you may not be able to show that you are eligible. If another health care provider has asked us to provide a health care service to you, such as a test or evaluation, and you do not give us written permission to release your information to them, then we may not provide you with that health care service.

To the recipients of protected health care information: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature:

Email: