Trillium FAMILY SERVICES℠

Release of Information/Documentation – Authorization Form

3415 SE Powell Blvd, Portland, OR 97202
Phone 503.234.9591 Fax 503.205.0188

Client Name:_____DOB:_____Client #:_____
Please Print

Please provide any other names used by client: _____

Regarding the records of the above identified client

I hereby authorize: TRILLIUM FAMILY SERVICES to exchange information/documentation with:

Agency NAME:_____Contact/Individual NAME:_____

ADDRESS:_____

Relationship to Client/Role in Treatment: _____

Primary Phone #_____ Fax # _____

1st Alt Phone#_____ 2nd Alt Phone #_____

Email address (encrypted use only – please print) _____

☐ **Emergency Contact** ☐ **Invite to Treatment Meetings** ☐ **Call if involved in Manual Restraint/Seclusion**

For the purpose of: Check any/all that apply

☐ Continuation of Care ☐ Legal ☐ Other _____

- I understand this authorization to release information and request to release or obtain records and information from my records and my request is voluntary and is not a condition of receiving treatment.
- I release the source of these records from any liability arising from their release.
- **I understand that my records will contain Mental Health Records, Medical Information and may contain references to drug and alcohol use or history, relevant genetic information and HIV/AIDS/STD lab results if pertinent to the stated purpose.**
- I authorize the parties above to talk by telephone about my referral, diagnosis, treatment and similar topics relevant to the above listed purpose.
- **I understand that Trillium Family Services is bound by the minimum necessary standard and will restrict their release to information and documentation that applies to the above listed purpose.**
- I understand that information used or disclosed based on this authorization may be subject to redisclosure and could no longer be protected by the federal and state laws on use and disclosure. (42CFR Part2)
- I understand that I may revoke this authorization at any time in writing directly with our Health Information Dept, but that information may have already been shared and the revocation will have no effect on what was already shared.
- **This authorization will expire automatically 1 year from the date on which it is signed or on another date if specified here**: **Expiration Date: ____/____/_____**

PRINT NAME Signature Date of Signature

☐ Parent ☐ Guardian ☐ Patient ☐ Other Relationship to Client _____

PRINT Name of witness **IF PRESENT** Signature of witness Date

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.