Patti Bear, Licensed Professional Counselor

1442 Pearl Street, Unit A, Eugene, OR 97401

pattibearlpc.com

541-357-7468

Authorization to Share Protected Health Information

Client Name: _____ Date of Birth: _____

I authorize Patti Bear, LPC, to exchange information with the following person or agency for the purpose of coordinating services and/or evaluating my/my child's needs:

Name of individual or agency: _____

Phone and/or address: _____

Specific information to be exchanged includes (please initial items you authorize):
_____Mental Health Services
_____Medical/Psychiatric treatment (diagnosis, treatment, prognosis)
_____Alcohol/Drug treatment (diagnosis, treatment, prognosis)
_____HIV testing (diagnosis, treatment, prognosis)
_____Family History
_____Employment/Unemployment
_____Educational reports/information (both academic and behavioral)
_____Other: _____

This permission is good for one year from the date of the signature below, or until: _____

I understand that I may revoke this authorization in writing at any time. Information exchanged previous to the time that I revoke this authorization will not be subject to the revoked authorization, but information received will no longer be used or disclosed for the purposes described in this authorization.

I understand that information disclosed due to this authorization may be subject to redisclosure and no longer protected under federal law. I understand that federal or state law may restrict redisclosure of specific health information, such as HIV/AIDS, mental health, drug and alcohol, and genetic testing information.

I understand that I do not have to sign this authorization and that refusal to sign will not adversely affect my ability to receive services. The only circumstance when refusal to sign this authorization restricts services is if the services are solely for the purpose of providing health information to someone else and authorization is needed to make the disclosure.

_____ _____

Client/Parent/Guardian signature Date