Pete A. Morones, Ph.D.
Licensed Psychologist

3310 SE Division Street Portland, OR 97202 (503) 236-4665

AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

Name:_____ Date of Birth: _____

I authorize Dr. Pete Morones ☐ To Obtain and/or ☐ To Release information as indicated below:

Name of Person and/or Agency: _____

Mailing Address: _____
City State Zip

Telephone: _____ Fax: _____

The purpose of this Authorization is: ☐ Assessment ☐ Treatment ☐ Insurance Purposes (e.g., authorization for treatment, billing, coordination of benefits, quality improvement, and/or utilization review)
☐ Other _____

By ***initialing*** below, I specifically authorize the release and/or receipt of the following information. Information may be transmitted via photo-copied records, fax, telephone, or other electronic means; and/or verbal communication unless noted otherwise:

_____All Medical Records*

_____Psychological/Psychiatric Care (e.g., Diagnosis, Symptoms, Drug/Alcohol Information*, Progress in Treatment Plan, Referrals, General Impressions & Information)

_____Psychological Notes & Evaluations (e.g., Psychotherapy Notes, Initial Evaluation, Closing or Discharge Evaluations/Summaries, Assessment Reports, Testing/Evaluation Data)

_____Physical Health Care (e.g., Evaluations, Notes, Diagnosis, Medication, Recommendations, Labs, Hospitalizations, Referrals, HIV info*)

_____Information Specific to: _____

Specific conditions, limitation, or time periods of the information to release: _____

I understand that my records are protected under federal privacy and confidentiality regulations (including alcohol & drug, mental health, genetic testing and HIV disclosure restrictions) and cannot be disclosed without my written consent unless otherwise provided for above or in the regulations. I understand that the information used/disclosed pursuant to this authorization may be subject to re-disclosure. I have had the opportunity to discuss the conditions of this form and have these conditions explained to me and to have my questions satisfactorily answered. I understand that I am not obligated to sign this release form and that I may revoke this authorization at any time with the exception of action already taken based on my previous approval. Unless otherwise noted, this release will be considered valid for one year from the date signed or while I am active in treatment. This release will also be considered valid for a period reasonable for the processing of a request for information, claim payment, or quality improvement review.

Client Signature (or Personal Representative):**_____ **Date:**_____

****Description of personal representative's authority:**_____

Release Revoked: ☐ Date:_____ Initials:_____

*If part of the information to be released includes HIV and/or alcohol & drug information, you must specifically initial the corresponding section in order to comply with federal and state regulations.