

# Release of Information - Mental Health Treatment

## Dr. Sanderson and Associates, LLC

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

I, \_\_\_\_\_ [Insert Name of Client], whose Date of Birth is \_\_\_\_\_, Dr. Sanderson and Associates, LLC disclose to and/or obtain from:

Name:

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Phone:

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Email:

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Fax: \_\_\_\_\_

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed):

- \_\_\_\_\_ Assessment
- \_\_\_\_\_ Diagnosis
- \_\_\_\_\_ Psychosocial Evaluation
- \_\_\_\_\_ Psychological Evaluation
- \_\_\_\_\_ Treatment Plan or Summary
- \_\_\_\_\_ Current Treatment Update
- \_\_\_\_\_ Presence/Participation in Treatment
- \_\_\_\_\_ Educational Information
- \_\_\_\_\_ Discharge/Transfer Summary
- \_\_\_\_\_ Continuing Care Plan
- \_\_\_\_\_ Progress in Treatment
- \_\_\_\_\_ Demographic Information
- \_\_\_\_\_ Other
- \_\_\_\_\_ Other

**Revocation:** I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Dr. Sanderson and Associates, LLC (901 Brutscher Rd, D141, Newberg OR, 97132)

Expiration: Unless sooner revoked, this authorization expires one year from today's date: \_\_\_\_\_ or as otherwise indicated: \_\_\_\_\_.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records.

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Signature of Patient/Client

Date

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Signature of Parent or Guardian

Date

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Signature of Staff

Date