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: _____
Phone: _____
Email: _____
Fax:_____

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

_____ Assessment	_____ Presence/Participation in Treatment
_____ Diagnosis	_____ Educational Information
_____ Psychosocial Evaluation	_____ Discharge/Transfer Summary
_____ Psychological Evaluation	_____ Continuing Care Plan
_____ Treatment Plan or Summary	_____ Progress in Treatment
_____ Current Treatment Update	_____ 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.

_____
Signature of Patient/Client Date

_____
Signature of Parent or Guardian Date

_____
Signature of Staff Date