RIVER BEND THERAPY, LLC
AUTHORIZATION TO USE AND DISCLOSE INFORMATION

Client

Client Name: _____ Birth Date: _____ Phone #: _____

I authorize:

From

River Bend Therapy, LLC
320 Century Dr, Suite 405-175
Bend, Oregon 97702

OR

❒ This other entity (name/address /telephone of disclosing entity)
_____
_____
_____
_____

To use and/or disclose a copy of the information described below for the above-named client

Information is to be received and used by:

To

River Bend Therapy, LLC
320 Century Dr, Suite 405-175
Bend, Oregon 97702

OR

❒ This other entity (name/address /telephone of receiving entity)
_____
_____
_____
_____

Purpose

For the purpose(s) of:
❒ At the request of the client or legal/personal representative
❒ Referral
❒ Case Coordination
❒ Consultation
❒ Other purposes (specify each purpose): _____
_____
_____

Info to be Disclosed

Description or nature of information to be used and/or disclosed: (initial all that apply)

____ Contact Information
____ Educational records and assessments
____ Goals and Objectives
____ Treatment/Progress Summary
____ Treatment Notes
____ Social History
____ Other: _____

____ Diagnostic Evaluation
____ Audiology Report
____ Neuropsychology Report
____ Otolaryngology Report
____ Physician's Report

____ Records for the following dates or treatment:_____

Specially Protected Information:
If the information to be disclosed contains any of these types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.
____ Mental health treatment records
____ Drug/Alcohol abuse diagnosis, treatment, & referral records
____ Information re: HIV/AIDS/Sexually transmitted diseases
____ Information re: Genetic testing (Oregon)

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Notices

1. I understand that I do not need to sign this authorization. Refusal to sign will not adversely affect my ability to receive services or reimbursement for services. The only circumstance when refusal to sign means I will not receive services is if the services are solely for the purpose of providing information to someone else and the authorization is necessary to make that disclosure.
2. I may revoke this authorization in writing at any time. If I revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, I must send a written statement to River Bend Therapy, LLC 320 Century Dr, Suite 405-175, Bend, OR 97702, and state that I am revoking this authorization.

Dates

Unless revoked, this authorization is valid for:
❒ One year from the date of signature below
❒ Upon termination/completion of services
❒ For the following specific time period:
Beginning date:_____ Ending (expiration) date: _____

Signature

SIGNATURE:
I have read this authorization, and I understand it.

_____ _____
Signature of Client or legal/personal representative Date

Description of personal representative's authority:

_____