AUTHORIZATION FOR RELEASE OF INFORMATION

Name:_____DOB.:_____

I authorize Rory F. Richardson, Ph.D., FICPPM (P.O. Box 109, Lincoln City, Oregon 97367; FAX: 541-994-6329)

✗_____**to provide information to** *and/or* ✗_____**request information from:**

Richard Bingham, M.D.

I FURTHER AGREE and AUTHORIZE that the person/agency listed to the left herein may share and exchange information (including by oral and/or written records) with Rory F. Richardson, Ph.D., FICPPM about me and my circumstances.

✗_____***initials***

By initialing the spaces below, I specifically authorize the release of the following records, if such records exist:

PHYSICAL HEALTH RECORDS*

(initial)

✗_____ Admissions & Discharge Summary
✗_____ History & Physical Examination Records
✗_____ Consultation Reports
✗_____ Medication Records
✗_____ Chart notes

RECORDS REQUESTED/RELEASED [*required*]
FROM (date) at birth (see DOB above)
TO (date) 10/01/2010

MENTAL HEALTH, ADDICTIONS (ALCOHOL, TOBACCO, OTHER DRUG, GAMBLING*

(initial)

✗_____ Mental Health Assessments/evaluations
✗_____ Progress Notes and Case Management Notes
✗_____ Treatment Plans and Reviews
✗_____ Psychological & Neuropsychological Evaluation
✗_____Psychoeducational records and assessment
✗_____ Drug/Alcohol diagnosis, treatment, & discharge information
✗_____Discharge summaries

***I understand that the information in my records may include information relating to sexually transmitted disease, mental health services, and treatment for alcohol, tobacco, or other drug abuse.** Alcohol/Drug, Mental Health, and Medical Records include all aspects of diagnosis, treatment and prognosis. [Excluding HIV/AIDS and Genetic testing information which requires a special, separate authorization). **This permission is good until: 10/01/2010**

✗_____ (initial) I specifically consent to transmission of my medical record via facsimile (fax)

PURPOSE: The information received will be used to evaluate my situation and to plan for and coordinate services for me, or for other purposes as specified: COORDINATION OF TREATMENT & CONTINUUM OF CARE

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

☐ Client ☐ Guardian
☐ Parent ☐ Legal Custody

✗_____ _____
Signature Date

_____ _____
Witness Signature Date

This is a true copy of the original authorization document_____