Bill McClain, LCSW
Child, Family, and Individual Counseling

Authorization to Use and Disclose Client Health Information

I, _____,
authorize Bill McClain, LCSW, to use, disclose and exchange personal protected health and mental health information pertaining to _____ date of birth_____
Client Name
To (Name and Address):

For the Purpose of:
Assessment, Evaluation and Diagnosis _____
Treatment Planning and Facilitation _____
Other consisting of _____ _____

By initialing the spaces below, I specifically authorize the disclosure of the following :
Enrollment in treatment _____
Treatment Information _____
Treatment plan, prognosis & progress _____
Educational Information, Assessments, Testing and Plans (including IFSP or IEP) _____
Diagnosis, symptoms & functional status _____
Results of clinical & psychological testing _____
Psych/Medical Reports _____
Medication prescriptions _____
Clinician chart notes (but not psychotherapy notes, which hold special protections of privacy) _____
All hospital or in-patient treatment records (includes nursing records/progress notes) _____
Medical records needed for continuity of care _____
Drug/Alcohol Use or Treatment _____
Emergency and urgency care records _____
Family Therapy Information _____
Payment records & billing statements _____
Other consisting of _____ _____

YOUR RIGHTS: Your signature on this Authorization cannot be required to receive your health care and payment for that health care, unless the health treatment is for the purpose of: 1) Creating health information about you to be disclosed to a third party or 2) For the purpose of research.
You have the right not to sign this Authorization. You have the right to revoke this Authorization at any time. If you revoke your Authorization, I will no longer use or disclose the above information about you, but I cannot take back any disclosures already made with your permission. To revoke this Authorization, please send a written statement to Bill McClain, LCSW 1679 Willamette St., Eugene, Oregon, 97401 that identifies the date of this Authorization and the recipient of the information listed in this Authorization, and state you are revoking this Authorization. This Authorization will expire automatically on the earlier of _____, or one year from the date of signing.

_____ _____
Signature of Client or Legal Guardian/Representative Date

_____
Relationship to Client

By signing this Authorization, I am indicating that I have reviewed and understand this Authorization. I am directing my health care provider to disclose my health information to another person or organization that may not have or obey the same obligations to protect privacy under state or federal law. Therefore, the disclosure of the information specified above carries with it the potential for an unauthorized redisclosure and loss of protection under state and federal law.