



Bill McClain, LCSW
Individual & Family Counseling

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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 _____

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.