**AUTHORIZATION FOR RELEASE OF INFORMATION**

Client Name: Date of Birth:

Address: City, State, Zip:

Phone: School/Grade:

I authorize Ronnie Hansen, LCSW, to release and obtain information to and from:

Name of Person/Provider/Facility/School:

Address:

Phone:

**TYPE OF RECORDS AUTHORIZED (initial all that apply):**

\_\_\_\_\_ Financial Records

\_\_\_\_\_ Medical Records

\_\_\_\_\_ Drug and Alcohol Evaluations and Treatment Plans

\_\_\_\_\_ Educational Records

**SPECIFIC INFORMATION AUTHORIZED (check all that apply):**

Assessments/Evaluations Treatment Plans

Progress Notes Treatment/Discharge Summary

Billing Invoices Functional Behave Assessment/Behave Support Plan

**FOR THE PURPOSE OF (check all that apply):**

Behavior Consultation Mental Health Treatment/Therapy

**I UNDERSTAND THAT:**

* I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
* I may revoke this authorization at any time by submitting a written request to Ronnie Hansen, LCSW, at 710 SW 57th Street, Corvallis, OR 97333, except where a disclosure has already been made in reliance on my prior authorization.
* Federal privacy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.
* Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.
* I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law, see 45 CFR § 164.524).
* This authorization expires on \_\_\_\_\_\_\_\_\_\_ (not to exceed one year from signature below).

Client Signature: Date:

Guardian Signature: Date: