995 Willagellespie Road, Suite 100
Eugene, OR 97401-2186
Phone 541-246-7263
Fax 541-343-7360

Authorization for Release of and/or Verbal Exchange of Protected and Confidential Health Information

I hereby consent and authorize Thrive Behavioral Health to: **(*You must INITIAL each)***

_____Send/receive a copy of my specific health information to/from person or entity named below

_____Verbally exchange specific health information with person or organization named below

Records released are limited to the last 2 years of information unless otherwise requested. **(*You must INITIAL each)***

_____ Personal Health History _____ Chart Notes _____ Laboratory _____ Pharmacy _____ Immunization _____ X-Ray Image

_____ Physical Therapy /Sports _____ X-Ray Reports _____Other:_____

Protected records require specific authorization for release. ***(You must INITIAL each selection requested.)***

_____ Mental/Behavioral Health Diagnosis

_____ Mental/Behavioral Health Progress Notes

_____ Drug/Alcohol Testing & Treatment

_____ Genetic Testing

_____ Mental/Behavioral Health Treatment Plan

_____ Psychoeducational/Neurobehavioral Evaluation

_____ HIV/AIDS Testing & Progress Notes

_____ IEP/IFSP/504 Plan

Release To/From:

Organization: _____

Provider Name (if applicable): _____ Address: _____

City/State/Zip:_____ Phone: _____ Fax: _____

For the purpose of:

_____Assessment/Treatment planning _____Other: _____

RE-RELEASE STATEMENT: Once the information is released pursuant to this authorization, it may be re-released by the recipient without knowledge or consent of the Thrive Behavioral Health or by the patient. Re-release may not be protected by Federal or State privacy regulations. The patient has the right to revoke this authorization at any time, except after the Thrive Behavioral Health has taken action in reliance on this authorization, or if the authorization was obtained as a condition of obtaining insurance. To revoke this authorization, a written signed statement revoking authorization must be brought, mailed or faxed to Thrive Behavioral Health. **____** ***(Initial)***

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my medical information. This authorization includes communication of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS-related illness, and/or HIV test results (if applicable) unless I limit the discussion to exclude the following medical conditions: **_____** ***(Initial)***

I have read this authorization and understand it. This Authorization will expire in **one year** from signature unless otherwise indicated below: Ends on (date) _____

Patient's Name (please print):_____

Patient's Signature:_____ Date: _____

Parent's Name (please print):

Parent's Signature: _____ Date:_____

If a representative on behalf of the patient signs this Release, complete the following: (See back for instructions)

Representative's Name: _____

Relationship to Patient:_____

If at any time I do not want verbal discussions permitted between my Health Care Providers and any individuals named above, I must contact Thrive Behavioral Health and notify my provider in writing. **_____** ***(Initial)***

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ADDITIONAL INFORMATION REGARDING COMMUNICATION OF PATIENT MEDICAL INFORMATION

Thrive Behavioral Health upholds a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign: You are not under any obligation to sign this form, and you may refuse to do so. Thrive Behavioral Health may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation: You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any communication of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. Your revocation must be made in writing and addressed to Thrive Behavioral Health.

Who May Sign This Authorization:

Generally, all patients 18 years of age or older must sign for communication of their own health information unless the following conditions apply:

The patient is incompetent

The patient is disabled and cannot sign the form

All persons signing for communication of health information on behalf of the patient must state their relationship to the patient and provide proof of legal authority of their capacity to act for the patient.

Minors: Patients less than 18 years of age must sign for communication of their health information in the following cases:

Alcohol or other drug abuse treatment: age 12 or older

Mental Health treatment: age 14 or older may consent to communication of their records without parental consent (Parents also retain the right to access this information)

HIV test results: age 14 or older

Emancipated minors who are married or in the military.