



Dina Yerex, LPC, CADC III

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Request/Authorization to Release Confidential Health Records and Information

Client Name: _____ Date of Birth: _____

I authorize the following individual or agency to provide / exchange the following information with Dina Yerex, LPC:

Name Relationship

Phone Fax

Address City State Zip

_____ I authorize this release of information to include any information about **mental health treatment or evaluation**, to include information pertaining to hospital records, medical records, laboratory reports, school records, sexual assault, and child abuse and neglect.

_____ I authorize this release of information to include any **alcohol / drug / gambling diagnosis, treatment, and prognosis information**. I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations (CFR) governing confidentiality of alcohol and drug abuse patient records. **Recipients of this information may re-disclose it only with my written consent** or as permitted by 42 CFR Part 2.

_____ I authorize this release of information to include any **HIV (AIDS) diagnosis, treatment, and prognosis information**.

The records and information concern the following time frame:

_____ Last 6 months _____ Last 1 Year _____ Last 2 Years _____ All _____ At Time of Emergency Only
_____ Other: _____

The kind(s) of information to be disclosed (in discussion or in writing) is: (initial below)

_____ Mental Health Assessment (including questionnaires) _____ Treatment Plan(s)
_____ Alcohol & Drug Assessment (including questionnaires) _____ Treatment Attendance
_____ Medical History and Evaluation(s) _____ Progress Notes and/or Treatment Summary
_____ Developmental and/or Social History _____ Discharge Summary
_____ Status In Event of Emergency _____ Invoices and/or Statements
_____ Other: _____

The purpose or need for the disclosure of information is: (initial below)

_____ Diagnosis / Evaluation _____ Treatment Planning / Ongoing Treatment
_____ Coordination of Services _____ Notification In Event of Emergency
_____ Billing _____ Coordinate Appointments
_____ Other: _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I have the right to cancel this consent for release of information, either by verbal request or in writing, at any time except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed.

Client Signature

Printed Name

Date