



# Release of Information

Client's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Information to Be Used or Disclosed

Information to be obtained under this authorization includes:

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## Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

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## Person or Organization Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

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Name of person/organization

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Address/Phone/Fax

## Therapist or Organization to Whom Information may be Disclosed

Information described above may be disclosed to:

Old Mill Center for Children and Families

Name of person/organization

1650 SW 45<sup>th</sup> Pl., Corvallis, OR 97333      (541)757-8068      (541)758-1030

Address

Phone

Fax

### Expiration of Authorization

This authorization is effective for a year from the date signed (unless revoked or terminated by the patient, or the legal guardian.)

### Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Old Mill Center.

### Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

### Rights of the individual

You may inspect or request a copy (in writing) of information that is used or disclosed under this authorization. You may refuse to sign this authorization. Refusal to sign this authorization will not impact services to be delivered.

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Signature of Individual Served (if 14 or older)

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Date

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Name of Legal Guardian (Please Print)

(Required if the individual served is a minor or an adult who is unable to sign this form)

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Signature of Legal Guardian

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Relationship to Individual

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Date

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Name of Legal Guardian (Please Print)

(Required if the individual served is a minor or an adult who is unable to sign this form)

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Signature of Legal Guardian

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Relationship to Individual

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Date