SPECTRUMS FAMILY SERVICES

Authorization to Release Confidential Records and Information

Client Full Name (print): _____ DOB: _____

I authorize Spectrums Family Services to disclose and/or obtain information about me or my child from:

Name of Organization: _____

Address of Organization: _____

Phone Number: _____ Fax Number: _____

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and coordinate treatment services. Or for other: _____.
The information to be disclosed relates to service dates beginning _____ and ending _____.

Please initial the information below to be released to Spectrums and/or received from the above entity:

_____ Assessments and Diagnoses
_____ Psychological evaluations or testing
_____ Medication Management
_____ Admission and discharge summaries
_____ Reports of teachers' observations
_____ HIV-related information
_____ Psychosocial evaluations
_____ Psychiatric evaluations
_____ Treatment plans and summaries
_____ Psychotherapy notes
_____ Educational Information
_____ Drug and alcohol information

Please fax or email the requested information to:
Spectrums Family Services
8196 SW Hall Blvd., Ste. 202, Beaverton, OR 97008
Secured Fax: 503.716.4715
Secured Email: secure@spectrumsfamily.com
Office Phone: 503.567.1820

Form of Disclosure: Unless I have specifically requested in writing that the disclosure be made in a certain format, I understand Spectrums reserves the right to disclose information as permitted by this authorization in any manner deemed appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically. I acknowledge that all electronic communication compromises my or my child's confidentiality. This includes email, text, Facebook, etc. If I choose to break confidentiality in any way (such as applying for insurance reimbursement or telling anyone about therapy), Spectrums Family Services cannot control or be held liable for the outcome.

Redisclosure: I understand there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations.

I have had explained to me and fully understand this authorization is to release records and information, including the nature of the records, their content, and the likely consequences and implications of their release. I hereby release the source of the records from any and all liability arising therefrom. This request is entirely voluntary on my part. I understand that I may take back this consent in writing at any time. This consent will expire automatically after 12 months from the date on which it is signed.

_____	_____	_____
Signature of Client (if 14 or older)	Printed Name	Date
_____	_____	_____
Signature of Parent/Guardian	Printed Name and Relationship	Date
_____	_____	_____
Signature of witness	Printed name	Date