



# Oregon

John A. Kitzhaber, MD, Governor

**State Board of Licensed Social Workers**

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## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_  
(PRINT the name of person or agency authorizing release of confidential information)

**Hereby authorize the following individual or agency:**

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Daytime Telephone)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Fax Number)

\_\_\_\_\_  
(City, State & Zip Code)

\_\_\_\_\_  
(Email Address)

**to provide information to the STATE OF OREGON BOARD OF LICENSED SOCIAL WORKERS (BOARD).**

This disclosure is at my request and for the purpose of assisting the Board in any review, investigation, or action related to administering or enforcing Oregon Revised Statutes (ORS) 675.510 to 675.600 and ORS Chapter 676 accordingly, as well as Oregon Administrative Rule, Chapter 877.

I consent to the release of all information requested by the Board, including but not limited to alcohol/drug assessment(s) and/or treatment(s), HIV/AIDS information, medical and psychiatric treatment, and mental health records obtained in the course of my diagnosis and treatment. I understand that such information cannot be released without my specific consent, except in a medical emergency. I further understand that the information disclosed may contain information that is protected by Federal law 45 CFR § 164, and/or State law, and I specifically consent to disclosure of such information.

I acknowledge, understand, and agree that:

- (a) This authorization is subject to revocation in writing at any time except to the extent that the party which is to make the disclosure has already taken action in reliance on it;
- (b) To revoke this authorization prior to the stated expiration date below, I must send a written statement to the Board that I am revoking this authorization and such revocation is effective only upon receipt; and
- (c) A copy of this original signed and dated authorization shall be as binding as the original.

If not previously revoked, this authorization is valid for the later of six (6) months from the date signed below, or until

\_\_\_\_\_ (Specific date, event, condition).

**\*\* I HAVE FULLY READ THIS AUTHORIZATION AND UNDERSTAND IT COMPLETELY \*\***

\_\_\_\_\_  
Signature (Patient, Guardian, or Legal Representative) Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Daytime Telephone

\_\_\_\_\_  
Address

\_\_\_\_\_  
Evening Telephone

\_\_\_\_\_  
Relationship to Patient (If Applicable)

FOR OFFICE USE ONLY:

EXPIRES ON: \_\_\_\_\_

