

EXAMPLE
For Demonstration Purposes Only

Disciplinary Supervisor's Letterhead
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

*(This authorization must be written, dated, and signed by the client or
by a person authorized by law to give authorization.)*

Client Name: _____ DOB: _____

I authorize _____ to: _____ obtain protected information from
And/or
_____ provide protected information to:

Oregon Board of Psychology

3218 Pringle Rd. SE, Ste. 130
Salem, OR 97302-6309

For the purpose of disciplinary supervision compliance, and fitness to practice.

By initialing each relevant space below I specifically authorize the information to be used on my behalf for the following purpose(s):

- | | |
|---|---|
| <input type="checkbox"/> Treatment Planning | <input type="checkbox"/> Insurance/Quality Assurance/Utilization Review |
| <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> At the Request of the Individual |
| <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> Other: |

By initialing the relevant spaces below, I specifically authorize the release of the following mental health records, if such records exist:

- | | |
|--|--|
| <input type="checkbox"/> Intake summary and treatment Plan | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Clinical Record | <input type="checkbox"/> Psychological Testing Reports |
| <input type="checkbox"/> Most recent 5 year history | <input type="checkbox"/> Emergency Room Notes |
| <input type="checkbox"/> Verbal or Written summary of treatment, with diagnoses | |
| <input type="checkbox"/> Drug/alcohol diagnoses, treatment or referral (specify): _____ | |
| <input type="checkbox"/> Other: Report all records pertinent to OBOP order and supervision | |

This authorization is limited to the following time period: Duration of supervision per OBOP Order

__ This authorization is limited to the following treatment: As outlined in OBOP Order

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization. To revoke this authorization, please send a written statement to the person who was originally authorized to release the information and state that you are revoking this authorization.

SIGNATURE

I have carefully read and understand this authorization and I understand it. Unless revoked, this authorization expires on

_____ (insert either applicable date or event)

By: _____ (individual or personal representative)

Date Signed: _____

Description of personal representative's authority, if appropriate:

