To those receiving information under this authorization: This information has been disclosed to you from records whose confidentiality is protected by state and federal law (42 CFR Part 2, ORS 192.501, ORS 502.505, ORS 179.505). You are prohibited from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by these laws and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

AUTHORIZATION TO USE/DISCLOSE HEALTH AND CLINICAL INFORMATION

I authorize _____ and Lori Cunnington, LCSW to use, disclose and exchange
(Name of Agency/Individual)

clinical information concerning _____.DOB_____
(Name of Child or Adult)

Please initial each checked box
Including records of:

_____ Educational Records (Progress and Behavior)
_____ Social Work Reports/Plan/Contracts
_____ Family Medical History
_____ Health / Immunization Records
_____ Mental Health Service Reports
_____ Medical / Psychiatric Treatment
_____ Other:_____

Note: Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. The records disclosed may include psychological and psychiatric records. The information exchanged may include verbal communication.

Purpose of disclosure: The exchange of information will be used to evaluate needs and to assist in providing services for the above child/family/individual for the following purposes:

_____ Evaluation
_____ Treatment
_____ Coordination of Services
_____ Other:_____

(Initial Here) _____ I agree that the agencies/individuals listed above may share and exchange information about the family of the child, and/or family members and or individual listed above and may release reports of family therapy.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, I will no longer use or disclose information about you for the reasons covered by your written Authorization, but I cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Lori Cunnington , LCSW, PO Box 1045, Veneta, OR 97487

By signing this Authorization, you are directing me to disclose your health information to another person or agency that may not have or obey the same obligations to protect privacy that I do under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for an unauthorized re-disclosure and loss of protection under state and federal law.

This Authorization will expire on: _____ Date

_____ One year from signing

_____ 90 days from termination with Lori Cunnington, LCSW

_____ End of period reasonably needed to accomplish disclosure for above-described purpose

I have reviewed and I understand this Authorization.

Signature _____

Relationship _____ Date _____

Lori Cunnington, LCSW
PHONE: (541)-206-2718
MAIL: PO Box 1045 Veneta, OR 97487