ROSE CITY GEROPSYCHOLOGY, LLC
AUTHORIZATION TO RELEASE INFORMATION

Phone: 503-902-5552
Fax: 877-991-9601

I, **(name of patient)** _____ DOB: _____, hereby authorize **Rose City Geropsychology** to disclose mental health treatment information and records obtained in the course of my psychotherapy treatment to:

_____
(name and contact information for person/organization to whom disclosure will be made)

This disclosure of information and records is required for the following purpose:

☐ To further mental health evaluation, treatment, or care ☐ Other: _____

☐ To notify my identified emergency contact in the case of an emergency

Such disclosure shall be limited to the following specific types of information:

☐ Medical history and evaluations ☐ Assessment and treatment history

☐ Mental health history ☐ Other: _____

HIV and drug/alcohol information will be released with the above information unless this box is checked: ☐ Do not release

I understand that:

- I have a right to receive a copy of this authorization.
- Any cancellation or modification of this authorization must be in writing and received by Rose City Geropsychology at P.O. Box 86816, Portland, OR 97286 to be effective. I have the right to revoke this authorization at any time unless my therapist has taken action in reliance upon it.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Oregon law may protect such information.
- My therapist shall not condition treatment upon signing this authorization and I have the right to refuse to sign this form.
- This authorization shall remain valid until one year or at the termination of mental health treatment, whichever is longer.

_____ _____ _____
Printed name of Patient/guardian Signature Date

If physically unable to sign, a witness can sign in the person's place: I witnessed that the person above understood the nature of this authorization, but was physically unable to sign.

_____ _____ _____
Printed name of witness Signature Date