Transitions Professional Center, LLC
Psychologists specializing in health, rehabilitation, palliative care & bereavement
3735 SW River Parkway ~ Portland, Oregon 97239 ~ 503.972.7090

AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I (we) _____ _____
Client name(s) Street Address

_____ _____
Phone Number City State Zip Code

I **authorize Transitions Professional Center, LLC to give, exchange, or receive information from/with:**

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

I would like the following information released:
(information to be released is marked by an X in the boxes below, while those items not to be released are crossed out).
☐ Medical History and evaluations ☐ Assessment and treatment history ☐ Mental Health History

☐ Other: _____

I understand the purpose of the information exchange will be:
☐ To further mental health evaluation, treatment, or care ☐ Other: _____

_____

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

I understand that:

- This consent will expire after one year or at the termination of mental health treatment, whichever is longer.
- I understand that I may revoke this consent any time. I understand the revocation must be made in writing to the Transitions Professional Center, LLC at 3735 SW River Parkway, Portland, OR, 97239.
- I understand that the parties in receipt of these communications may redisclose my PHI (protected health information) to persons or entities that are not subject to the HIPAA privacy regulations, resulting in my PHI no longer being protected by HIPAA regulations.

_____ _____ _____
Signature of Client/guardian Printed Name 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.

_____ _____ _____
Signature of witness Printed Name Date