



Oregon

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I,

(PRINT THE NAME OF THE PERSON OR AGENCY AUTHORIZING RELEASE OF CONFIDENTIAL INFORMATION)

HEREBY AUTHORIZE THE FOLLOWING INDIVIDUAL OR AGENCY:

NAME:			
ADDRESS:		EMAIL:	
CITY:	STATE:	ZIP CODE:	

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 & AGREE THAT:

- 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 ACTEN TO RELIANCE ON IT;
- 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 & SUCH REVOCATION IS EFFECTIVE ONLY UPON RECEIPT; AND
- A COPY OF THIS ORIGINAL, SIGNED & 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 OR CONDITION)

*** I HAVE FULLY READ THIS AUTHORIZATION & UNDERSTAND IT COMPLETELY ***

PRINT NAME:			
ADDRESS:		EMAIL:	
CITY:	STATE:	ZIP CODE:	

RELATIONSHIP TO PATIENT
(IF APPLICABLE):

SIGNATURE
(PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE)

DATE:

FOR OFFICE USE ONLY: (DATE REC'D)

FOR OFFICE USE ONLY:

EXPIRES ON: ___ / ___ / 20___