



Release of Information/Documentation – Authorization Form

Children's Farm Home 4455 NE Hwy 20 ▪ Corvallis OR 97330 ▪ (541) 757-1852
Parry Center/Waverly Programs 3415 SE Powell Blvd ▪ Portland OR 97202 ▪ (503) 234-9591

In regard to the records of:

Client Name: _____ DOB: _____ SSN: _____
Please Print

Please provide any other names used _____

I hereby authorize: **TRILLIUM FAMILY SERVICES** to mutually exchange information with:

Agency NAME: _____	ROLE/RELATIONSHIP TO CLIENT
Contact/Individual NAME: _____	____ Primary Care Physician:
ADDRESS: _____	____ Professional Role _____
_____	____ Other _____

Home Phone # _____ Message Ok? _____ Fax # _____

Cell Phone# _____ Message Ok? _____ Work Phone # _____ Message Ok? _____

For the purpose of: <input type="checkbox"/> Continuation of Care <input type="checkbox"/> Legal <input type="checkbox"/> Other _____ <small>Check any/all that apply</small> <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Invite to Treatment Meetings <input type="checkbox"/> Call if involved in Manual Restraint/Seclusion

INITIAL each documentation category that you are authorizing:		
_____ Mental Health Records	_____ Medical Information	_____ Drug and Alcohol Treatment
_____ Genetic Information	_____ HIV/AIDS	

- I understand this authorization to release information and request to release or obtain records and information from my records and my request is voluntary.
- I release the source of these records from any liability arising from their release.
- I authorize the parties above to talk by telephone about my referral, diagnosis, treatment and similar topics relevant to the above listed purpose.
- **I understand that Trillium Family Services is bound by the minimum necessary standard and will restrict their release to information and documentation that applies to the above listed purpose.**
- I understand that information used or disclosed based on this authorization may be subject to redisclosure and could no longer be protected by the federal and state laws on use and disclosure. (42CFR Part2)
- I understand signing this authorization is not a condition of receiving treatment.
- I understand that I may revoke this authorization at any time in writing via certified mail but that information may have already been shared and the revocation will have no effect on what was already shared.
- This authorization will expire automatically 1 year from the date on which it is signed or sooner than 1 year if a date is specified: ____ / ____ / ____.

_____ PRINT NAME	_____ Signature	_____ Date
<input type="checkbox"/> Parent	<input type="checkbox"/> Guardian	<input type="checkbox"/> Patient
<input type="checkbox"/> Other _____		

_____ Name of witness IF PRESENT (Please Print)	_____ Signature of witness	_____ Date
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To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.