



Release of Information – Authorization Form

Children's Farm Home 4455 NE Hwy 20 ▪ Corvallis OR 97330 ▪ (541) 758-5900
Parry Center/Waverly Programs 3415 SE Powell Blvd ▪ Portland OR 97202 ▪ (503) 234-9591

In regard to the records of:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_
Please Print

Please provide any other names used \_\_\_\_\_

I hereby authorize: TRILLIUM FAMILY SERVICES

To mutually exchange information with:

Individual/Agency Name: \_\_\_\_\_

Individual/Agency Address: \_\_\_\_\_

Name and Position/Role of Contact Person: \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

For the purpose of: [ ] Continuation of Care [ ] Educational Planning [ ] Legal [ ] Other \_\_\_\_\_

INITIAL each specific item or document type that you are authorizing:

Psychiatric Assessment Psychiatric Progress Notes Alcohol and Drug Treatment
Comprehensive Assessment Discharge Summary HIV/AIDS
Individual Plan of Care Medical Information Other
Treatment Reviews Mental Health Records

Telephone Messages can be left for the above named individual or agency at the following number(s): Home phone Work phone Cell Phone

I fully understand this authorization to release information and request to release or obtain records and information from my records as the nature of the records, their contents, the consequences and implications of its release, and my request is wholly voluntary on my part. I hereby 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 for this release of records. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and could no longer be protected by the applicable federal and state laws governing use and disclosure. I understand that provision of services is not contingent upon this releasing of records.

I understand that I may revoke this authorization at any time in writing via certified mail except to the extent that action based on this consent has been taken. This consent will expire either: automatically 1 year from the date on which it is signed, or upon the following date \_\_\_\_\_

Client Name (Please Print) Signature of client Date

Name of parent/authorized rep. (Please Print) Signature of parent/authorized rep (indicate authority) Date

Name of witness (Please Print) Signature of witness Date

Address & phone number of witness \_\_\_\_\_

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.