Reciprocal Release of Information

Date ______________

Client's Name ____ Client's Birthdate ______________________

Parent/Guardians (if client is under 18yo): ____

This is a **Reciprocal Release of Information**: This form authorizes the client's protected health information to be given to and received from the agencies/people listed below.

- I authorize The Hello Clinic and the agencies/people listed below to release all the mental health / medical / academic records.
- I am requesting this information be released to assist in diagnosis, assessment, treatment planning and therapy.
- This form authorizes both parties to receive and give protected health information about this client.
- I understand that federal or state law may restrict redisclosure of information of HIV/AIDS, mental health, genetic testing, and drug/alcohol diagnosis, treatment or referral information.
- This authorization shall remain in effect for the duration of my work at The Hello Clinic or unless I revoke it in writing.
- This authorization may be revoked at any time. To do so, please send a written statement to The Hello Clinic, 10300 SW Greenburg Rd #410, Portland, OR 97223 and state that you are revoking this authorization.
- I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA privacy rule.

Please verify that you understand the Reciprocal Release of Information by signing and dating below:

Signature ____ Date ____________________

Below are the agencies / people allowed to both release and receive the client's protected health information:

Provider/Facility: The Hello Clinic Phone: 503-517-8555
Address: 10300 SW Greenburg Rd, #410 Portland, OR 97223 Fax: 503-517-8556

Provider/Facility: ____ Phone: ____________________
Address: ____ Fax: ____________________

Provider/Facility: ____ Phone: ____________________
Address: ____ Fax: ____________________

Provider/Facility: ____ Phone: ____________________
Address: ____ Fax: ____________________

The information listed below has additional laws relating to its use and disclosure. By initialing the spaces below, you state that you understand and agree that the following protected health information may be disclosed.

________ Mental Health Information

________ HIV / AIDS Information

________ Drug/Alcohol Diagnosis, treatment and referral information

________ Genetic Testing Information