HEATHER A. BACON, PH.D., LLC

LICENSED CLINICAL PSYCHOLOGIST

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INIFORMATION ORS 192.520

I, _____ (Patient's name/Consenting Adult/Patient Representative)
authorize mutual exchange of protected health information from my clinical record between **Heather A. Bacon, Ph.D. Licensed Clinical Psychologist** and

Name: _____

Mailing address: _____

Phone: _____ Fax: _____

I authorize and request the mutual exchange of this specific information:
_____ AT MY REQUEST _____ AT MY REQUEST FOR MY CHILD _____
(Patient's name)
PATIENT'S DOB: _____

Please initial next to each protected information that you authorize disclosure of.
_____ MENTAL HEALTH INFORMATION: SESSION NOTES/TREATMENT SUMMARY
_____ DRUG/ALCOHOL DIAGNOSIS, TREATMENT OR REFERRAL
_____ OTHER _____

For the purpose of:
Please initial next to each one that applies.
_____ COORDINATION OF CARE AND TREATMENT
_____ PSYCHOLOGICAL/ NEUROPSYCHOLOGICAL ASSESSMENT
_____ COLLATERAL/CONJOINT SESSION (i.e. Couples or Family Counseling)
_____ LEGAL REVIEW/CONSULTATION

This authorization will remain in effect 365 days from today's date or if earlier revoked. This authorization may be revoked in writing at any time. If this authorization is revoked, the information listed above will no longer be used or disclosed for the purposes described in this written authorization. In the case of collateral client requests for records, Dr. Bacon will require all parties' written consent before releasing information to a second party (spouse, attorney, etc.).

I understand that once information leaves this office, it is the responsibility of the recipient to protect the information according to the **ORS 192.520** and the **Health Insurance Portability and Accountability Act of 1996**.

By signing this form, I have read this authorization and understand it.

Signature of Patient/Guardian: _____ Date: _____
Description of patient's representative: _____

Signature of Witness: _____ Date: _____
Witness name (printed): _____