Authorization for Release of Protected Health Information (PHI) Integrative Trauma Treatment Center

811 NW 19th Avenue, Ste. 102
Portland, OR 97209
Phone: 971-266-6910 || Fax: 888-972-3623

— Mental Health Record

1. Patient Information

Patient last name_____First name_____MI_____Date of birth _____

Patient former name (if any)_____MRN _____

Patient address_____Patient e-mail _____
Street City State Zip

Patient home phone_____Work phone_____Cell phone _____

2. Recipient Authorization

I,_____, do hereby authorize_____to release a copy of my
Patient name or representative Provider or service (e.g., "Integrative Trauma Treatment Center")
mental health record to the person or facility below.

Name of person or facility to receive mental health record _____ Street address _____

City, state, ZIP _____ Phone _____

3. Information to be Released

This request does not apply to release of psychotherapy notes

☐ My entire mental health record

☐ Only those portions pertaining to:_____
(be specific; include provider name and date(s) of treatment, if applicable)

4. Purpose of Information Release

☐ Further mental health care ☐ Payment of insurance claim ☐ Legal investigation ☐ Coordination of care

☐ Vocational rehab, evaluation ☐ Disability determination ☐ At the request of the individual ☐ Other (specify): _____

5. Patient Rights and Privacy

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization by providing a written statement to ITTC, except to the extent that ITTC has already completed action on it.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release the ITTC from all legal responsibilities and liabilities that may arise from the release of such protected health information.
- I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for a period of six months, and it automatically expires six months after the date this form is executed.

6. Signature of Patient or Personal Representative:_____Date _____
Signature

Personal representative, print name: _____
Printed name of personal representative

If signed by a personal representative, state your relationship to patient and/or reason and legal authority for signing:

Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased

Legal authority: ☐ parent ☐ legal guardian ☐ next of kin of deceased

For ITTC use only

Date rcvd: _____ **Rcvd by** _____ **ID provided:** _____ **MRN:** _____

Date released:_____**Processed by:**_____ ☐ **Sent by mail** ☐ **Picked up in person**