Jill Leffingwell,LCSW

541 Willamette St. Suite 306, Eugene, OR 97401

I, ____,
authorize Jill Leffingwell, LCSW, to use, disclose and exchange personal protected health and mental health information pertaining to __________________________________date of birth___________
Client Name
To (Name and Address):

____

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For the Purpose of:

Assessment, Evaluation and Diagnosis _______
Treatment Planning and Facilitation _______
Other consisting of ____ _______
By initialing the spaces below, I specifically authorize the disclosure of the following :
Enrollment in treatment _______
Treatment Information _______
Treatment plan, prognosis & progress _________
Educational Information, Assessments, Testing and Plans (including IFSP or IEP) _______
Diagnosis, symptoms & functional status _______
Results of clinical & psychological testing _______
Psych/Medical Reports _______
Medication prescriptions ________
Clinician chart notes (but not psychotherapy notes, which hold special protections of privacy) ______
All hospital or in-patient treatment records (includes nursing records/progress notes) _______
Medical records needed for continuity of care _______
Drug/Alcohol Use or Treatment ________
Emergency and urgency care records _______
Family Therapy Information ________
Payment records & billing statements _________
Other consisting of ____ ______

YOUR RIGHTS: Your signature on this Authorization cannot be required to receive your health care and payment for that health care, unless the health treatment is for the purpose of: 1) Creating health information about you to be disclosed to a third party or 2) For the purpose of research.
You have the right not to sign this Authorization. You have the right to revoke this Authorization at any time. If you revoke your Authorization, I will no longer use or disclose the above information about you, but I cannot take back any disclosures already made with your permission. To revoke this Authorization, please send a written statement to Bill McClain, LCSW 1679 Willamette St., Eugene, Oregon, 97401 that identifies the date of this Authorization and the recipient of the information listed in this Authorization, and state you are revoking this Authorization. This Authorization will expire automatically on the earlier of_______________, or one year from the date of signing.

____ _________________

Signature of Client or Legal Guardian/Representative Date

By signing this Authorization, I am indicating that I have reviewed and understand this Authorization. I am directing my health care provider to disclose my health information to another person or organization that may not have or obey the same obligations to protect privacy under state or federal law. Therefore, the discloser of the information specified above carries with it the potential for an unauthorized redisclosure and loss of protection under state and federal law.