Your Path Forward Counseling
Lisa Sciarani, LCSW

1110 SE Alder Street Suite #301
Portland, OR 97214
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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH

Client Name: Jane Lee DOB: 05/05/1985

I Jane Lee (client's name) authorize *Lisa Sciarani, LCSW/*Your Path Forward to
☒ OBTAIN information from ☒ DISCLOSE information to

Contact Name: John Armstrong	Organization/Relationship: Partner
Address: 1234 Therapy Lane	Telephone: 503-555-5555
City, State, Zip: Portland, OR 97214	Fax: N/A

Information to be used/disclosed consists of mental health care information:
☐ All records, or ☒ Only the items checked below:
☐ Assessment or evaluation ☐ Treatment Plan ☐ Summary of Treatment
☐ Progress Notes ☐ Coordination of care information ☒ Other: For emergencies and safety planning only

The purpose for the disclosure/communication:
☐ Coordination of care ☐ By request of the client ☒ Other: In the event of an emergency or disruption in service

I understand that additional laws about mental health, alcohol/drug treatment, genetic testing, and HIV/AIDS may apply. I understand and agree that this information will be disclosed if I initial next to the type of PHI.

	Type of PHI
JL	Mental health information
JL	Alcohol/drug diagnoses, treatment, or referral information
	HIV/AIDS testing
	Genetic testing

Client Acknowledgment and Authorization
I understand that I am not required to sign this authorization. If I decline to sign this authorization, it will not prevent me from getting care. I understand that I may revoke this authorization in writing at any time, at which time any information described here may no longer be used or disclosed. Any information that has been used or disclosed prior to the revocation cannot be unshared. I understand that any information used or disclosed as a result of this authorization may be subject to re-disclosure. However, I also understand that federal and state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing, and drug/alcohol diagnoses, treatment or referral information.

Unless revoked, this authorization expires ***60 days after the completion of treatment*** or: _____

Client Signature — Date: 01/01/2023

Parent/Legal Guardian/Personal Representative Signature — Date

Parent/Legal Guardian/Personal Representative Name

Authority of representative: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney/Healthcare ☐ Other: _____