

CHRISTIAN WOLFF, Psy.A Licensed Psychologist Associate

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Authorization To Use or Disclose Health Information

I, _____
(Your Name) (Date of Birth) (Social Security Number)

authorize _____
(Name of Person or Organization SENDING information, Address, and Contact Number)

to disclose _____

(Describe the Type of Information)

TO: _____
(Name of Person or Organization RECEIVING information, Address, and Contact Number)

for _____
(Describe Purpose of Disclosure)

YES NO I authorize the above parties to send and receive information, to and from each other .

Check Yes or No and initial after each item: The law requires special permission to disclose the information below.

Y N

- I authorize use of standard forms of communication including telephone, fax, postal mail and e-mail. _____
- I specifically authorize disclosure of information regarding drug and alcohol use. _____
- I specifically authorize disclosure of information regarding HIV. _____

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that I have already used or disclosed information in reliance on this Authorization. This authorization shall be in effect for 180 days from the date it is signed unless otherwise indicated. Please initial in the following space or indicate an alternate end date: _____

By signing this authorization, you are acknowledging the fact that the other party may not have the same obligation to protect privacy as Christian Wolff does under state and federal law. Therefore, the disclosure described above carries with it, the potential for an unauthorized re-disclosure and loss of protection under state and federal law.

I have reviewed and understand this Authorization.

X	_____	_____
	(Signature)	(Date)
	_____	_____
	(Signature of Representative if Legally Required)	(Date)
X	_____	_____
	(Witness)	(Date)