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Main Office Fax: (503) 648-5269  
**ASSESSMENT/INTAKE: 971-777-0756**

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

PATIENT / CLIENT NAME \_\_\_\_\_ PATIENT CONTACT#: \_\_\_\_\_  
(PRINT) LAST NAME FIRST NAME MI  
(DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ Doc# \_\_\_\_\_ IJHAC ID# \_\_\_\_\_ )  
(IF APPLICABLE)

I AUTHORIZE INNER JOURNEY HEALING ARTS TO: \_\_\_\_\_ RELEASE RECORDS TO \_\_\_\_\_ REQUEST RECORDS FROM \_\_\_\_\_  
(PLEASE CHECK THE INFORMATION TO BE DISCLOSED BELOW)

TO: \_\_\_\_\_ FROM: INNER JOURNEY HEALING ARTS CENTER - OUTPATIENT  
PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ PHONE: 971-777-0756 OR (503) 543-6100  
EMAIL: \_\_\_\_\_ FAX: 503-648-5269

- EXAMPLES: ● COUNTY COURTS AND EVALUATORS ● INSURANCE PROVIDER ● WHHS/CARE OREGON ● ADES  
● PROBATION AND PAROLE ● VOA ● DHS ● PERSON ● DMV ● REDWOOD TOXICOLOGY/ABBOTT  
● PEER SUPPORT ● OHP INSURANCE LABORATORY ● TRI-MET ● MULTNOMAH COUNTY  
● PHTECH SUPPORT ● COLUMBIA COUNTY ● WASHINGTON COUNTY  
● OTHER: \_\_\_\_\_

THIS CONTENT IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT THE PROGRAM WHICH IS TO MAKE THE DISCLOSURE HAS ALREADY TAKEN ACTION IN RELIANCE ON IT, IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE UPON (SPECIFIC DATE, EVENT, OR CONDITION).  
( \_\_\_\_\_ )  
(c) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:  
(1) Has expired;  
(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;  
(3) Is known to have been revoked; or  
(4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.  
(Approved by the Office of Management and Budget under control number 0930-0099)

INFORMATION TO BE EXCHANGED AND DISCLOSED IS:  
(PLEASE INITIAL THE INFORMATION TO BE DISCLOSED)

- \_\_\_\_\_PRE-AUTHORIZATION FORM / INFORMATION\_\_\_\_\_  
\_\_\_\_\_DIAGNOSTIC AND REFERRAL REPORT\_\_\_\_\_CIRCUIT COURT  
\_\_\_\_\_URINALYSIS RESULTS (PRESENCE IN TX-PRESCRIBED RX MEDICATION)  
\_\_\_\_\_MEDICAL RECORDS\_\_\_\_\_EMERGENCY CONTACTS  
\_\_\_\_\_BEHAVIORAL HEALTH REPORTS\_\_\_\_\_PROGRESS REPORTS  
\_\_\_\_\_DISCHARGE SUMMARY\_\_\_\_\_OTHER/INSURANCE BILLING  
\_\_\_\_\_DMV (CERTIFICATE OF COMPLETION)\_\_\_\_\_PRESENCE IN TREATMENT  
\_\_\_\_\_RECORDS RELATED TO (SPECIFIC DATES, EVENT, OR CONDITION)\_\_\_\_\_

THE PURPOSE OF THE USE/DISCLOSURE IS FOR:  
CONTINUITY OF CARE TRANSFER OF CARE PERSONAL DISABILITY INSURANCE LEGAL OTHER SPECIFY) \_\_\_\_\_

SIGNATURE OF CLIENT / PATIENT: \_\_\_\_\_  
SIGNATURE OF PERSON AUTHORIZED TO SIGN IN LIEU OF THE PATIENT OR LEGAL GUARDIAN: \_\_\_\_\_  
(WHERE REQUIRED)  
DATE: \_\_\_\_\_ STAFF WITNESS \_\_\_\_\_

REV: 0523 2021

INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATION (42 CFR, PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATION ALSO RESTRICTS ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE THE PATIENT. THIS RELEASE OF CONFIDENTIAL INFORMATION WILL REMAIN IN EFFECT UNTIL THERE HAS BEEN A FORMAL AND EFFECTIVE TERMINATION OR REVOCATION OF MY DUII DIVERSION / A&D TREATMENT AGREEMENT, PROBATION, OR OTHER SPECIFIC REASON.