Inner Journey Healing Arts
COUNSELING • OUTPATIENT TREATMENT
"Treating the Body, Mind, & Spirit"

☐ 134 SE 5th Avenue, Suite C, Hillsboro, OR 97123
☐ 161 ST Helens Street, Suite 102, St Helens, OR 97051
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: _____

PHONE: _____ **FAX:**_____

EMAIL: _____

FROM: INNER JOURNEY HEALING ARTS CENTER - OUTPATIENT

PHONE: 971-777-0756

FAX: 503-648-5269

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

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(3) Is known to have been revoked; or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: 0501 2020