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

☐ 134 SE 5th Avenue, Suite C, Hillsboro, OR 97123
☐ 161 ST Helens Street, Suite 102, St Helens, OR 97051
Office eFax: (503) 214-8911
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#** __________ **JHAC 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 OR 503-543-6100
OFFICE FAX: Hillsboro: 503-214-8911

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). (enter 6 or 12 month end date)

(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(3) Is known to have been revoked; or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.

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

- ☐ PRE-AUTHORIZATION INFORMATION FORM
- ☐ URINALYSIS RESULTS
- ☐ PRESENCE IN TREATMENT
- ☐ DMV (CERTIFICATE OF COMPLETION)
- ☐ RECORDS RELATED TO (SPECIFIC DATES, EVENT, OR CONDITION)
- ☐ OTHER:
- ☐ MEDICAL RECORDS
- ☐ REFERRAL REPORT
- ☐ PROGRESS REPORT
- ☐ INSURANCE BILLING
- ☐ DISCHARGE SUMMARY
- ☐ PRESCRIBED Rx MEDICATION

THE PURPOSE OF THE USE/DISCLOSURE IS FOR:

☐ CONTINUITY OF CARE ☐ TRANSFER OF CARE ☐ PERSONAL ☐ DISABILITY ☐ INSURANCE ☐ LEGAL

☐ OTHER SPECIFY)__CLIENT ID#______________________________________

SIGNATURE OF CLIENT / PATIENT:____

SIGNATURE OF PERSON AUTHORIZED TO SIGN IN LIEU OF THE PATIENT OR LEGAL GUARDIAN: ____________________
(WHERE REQUIRED)

DATE: ______________ **STAFF WITNESS:** ______________________ ______________________

** CLIENT / PATIENT REFUSES TO SIGN **

Client / Patient Name: ____________________________ refuses to sign this sheet

As of Date: ______________________ Time: ______________

NOTICE PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION: *This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31).The federal rules restrict any use of information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.*