



Authorization for Use and Disclosure of Information (Release of Information)

Shangri-La
Enriching Lives Together

This form is available in alternative formats including large print or oral presentation.

Legal First Name of client/applicant:	Legal Last Name:	MI:	Date of birth:
Other names used by client/applicant:			

By signing this form, I authorize the following record holder to disclose the following specific information about me:

Section A	Release from <i>one</i> record holder: (Emergency Contact, Primary Care Provider, Hospital, Pharmacy, etc.)	Purpose:	Mutual Exchange:
	<i>Name/Agency:</i>	All medical and health records/ information needed to coordinate care.	YES
	<i>Phone Number:</i>		
	<i>Address:</i>		
<p>If the information contains any of the types of records of information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information.</p> <p>HIV/AIDs Information: _____ Genetic Testing Information: _____ Mental Health: _____</p> <p>Alcohol/drug diagnosis, treatment, referral: _____</p>			

Section B	Release to: (address required, if mailed):	Purpose:	Expiration date or event:
	<i>Shangri-La Outpatient Mental Health Clinic</i>	Provide Mental Health Assessment, Treatment and Services.	Termination/ cancellation of services.
	<i>398 High St. Eugene, OR 97401 and/or 4080 Reed Rd SE Ste 150 Salem, OR 97302</i>		
	(Lane) <i>Phone: 541-344-1121 Fax: 541-344-4780</i> (Marion) <i>Phone: 503-581-1732 x360 Fax: 503-363-4607</i>		
<p>*This authorization is valid until client discharge, unless otherwise specified:</p> <p><i>I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means, and I approve of the disclosures listed. I am signing this authorization of my own free will.</i></p> <p><i>I understand that the information used and disclosed as stated in the authorization may be subject to re-disclosure of HIV/AIDS, mental health and drug/alcohol diagnosis, treatment, vocational rehabilitation, record of referral information without specific authorization.</i></p>			

Section C	Full legal signature of individual/guardian:	Relationship to client (if not self):	Date:
	Name of staff person (print):	Initiating agency name/location:	Date: