Talk, Inc.
AUTHORIZATION FOR RELEASE OF INFORMATION

☐ Official Records Requested ☐ To Filing

➔ I, _____, _____ authorize
Print Individual's Full Name — Date of birth

Release from: (Name, fax, mailing address, city, state, zip, phone)	**Release to**: (Name, fax, mailing address, city, state, zip, phone)	***Initial*** for Mutual Exchange

➔**Reason for releasing records:** _____

➔ ***INITIAL*** **next to information to be released**

_____ Attendance/Eligibility/Compliance
_____ Course and progress in treatment
_____ Assessment/Treatment Plan
_____ Coordination of Services/Case Management
_____ Diagnosis or Status
_____ Discharge Summary
_____ Med Management (Notes/Med Log)
_____ Lab results/ Urinalysis Testing (UA)
_____ Health History, Physical Exam, Immunizations
_____ Social Information and Reports
_____ Court Proceedings (excluding expunged records)
_____ School/Educational Records
_____ Legal Records
_____ Financial Records
_____ Billing Statement / Information
_____ Other _____

➔ ***Initial*** **type of special information to be released (if any)**

____ Mental Health Information
____ Developmental Disabilities
____ Parent Coordination
____ Addictions Treatment Information
____ Genetic Testing Information
____ Collaborative Evaluation and Mediation
____ Other_____

➔**Date range of information to be released:** _____

Unless specified above, information will be limited to the most recent episode of care.

I understand that my records cannot be released without my written permission unless otherwise provided for in state and federal laws. I may cancel this permission at any time in writing but I understand this cancellation will not affect any information that was released prior to my written request. This permission will expire 365 days from date of signature (*or specify):*

_____
Specify other date, event or condition

I understand I may refuse to sign this form. I know in certain cases, I may be limited or denied treatment and other related services if I do not sign. I understand information about my case may be confidential and may be protected by state and federal laws. I approve the release of my health information. I am signing on my own and have not been pressured to do so. I acknowledge that I have been offered a copy of this form and the attached Privacy Practices.

➔ _____
Client Signature (age 14 and up)/ Guardian Signature (when required) — Print Name — Date

_____
Witness Signature — Print Name — Date

Talk, Inc. 1183 NW Wall St. Bend, OR 97701, Phone (541) 604-0262 or (541) 390-6322, Fax (541) 550-3862