Logstrom Counseling, LLC

Provider Contact/Release of Information

Dear Client,

Logstrom Counseling, LLC has a strong commitment to your holistic health. For that reason it is important to have a close working relationship with your physician, psychiatrist, or other healthcare provider. I am asking for your permission to communicate with your healthcare providers. I find that I can serve you best if they are aware of mental health and substance abuse concerns, which often impact health and well-being. Please complete the attached release to enable me to communicate with them about your care. If you have more than one provider, please let me know and I will provide you with additional forms. You will need to complete a separate release of information for each provider you wish me to communicate with during the course of your care at Logstrom Counseling, LLC. I will be happy to answer any of your questions or respond to your concerns regarding this matter.

If do not wish me to communicate with your other healthcare providers please check the appropriate response below and sign the bottom of this page.

Thank you.

Please check all that apply:

____ Yes, please communicate information about my care with my primary care physician. I have completed the release of information (that follows this page) with the contact information.
____ Yes, please communicate with providers other than my primary care physician. I have completed a release of information with the contact information.
____ No, I do not want Logstrom Counseling, LLC to communicate with my primary care physician.
____ No, I do not want Logstrom Counseling, LLC to communicate with other providers.

I understand that I may sign a release of information at any time for a specific provider and at that point Logstrom Counseling, LLC will initiate written or verbal communication with that provider.

Patient Signature_____ Date _____

Parent/Guardian Signature _____ Date _____

Logstrom Counseling, LLC

Consent for Release of Information

This authorizes Logstrom Counseling, LLC to use and disclose the specific health information described below concerning:

Client:_____ Date of Birth:_____

This will authorize Logstrom Counseling, LLC to release to and/or obtain from written and/or verbal information:

(Provider Name)_____

(Provider Address)_____(City)_____(State)_____(Zip)_____

(Provider Phone)_____ (Provider Fax)_____

Information from the medical record maintained from (please list dates such as "all" or 02/04 to 02/05):_____

The information to be disclosed is (please check all info that you are willing to have exchanged):

	History and intake information		Social/ Psychological/Medical reports
	Consultation notes/ progress reports		Chemical dependency abuse or diagnosis, history and treatment (protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505)
	Treatment plan, goals, and results		Medications used in treatment
	Court or probation records		Other (specify)

The purpose of the information release is (please check all that apply):

	Diagnosis and Evaluation		To Facilitate Treatment
	Treatment Planning		Other (specify)

If I am requesting the Authorization from you for my use and disclosure or to allow another healthcare professional or entity to disclose information to me: (I) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization; and (3) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of healthcare practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law.

_____ _____

Signature of Client Date

_____ _____

Signature of parent or guardian Date