

# CHARLENE SABIN, M.D., P.C.

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## Authorization to Use or Disclose Protected Health Information

I authorize Charlene Sabin, MD, PC, to use and disclose a copy of the specific mental health and medical information described below regarding:

Name of Client: \_\_\_\_\_ DOB: \_\_\_\_\_

As is necessary to release information to and/or receive information from:

\_\_\_\_\_  
Person or Organization  
\_\_\_\_\_  
Address/City/ZIP Phone/Fax Number

Date(s) of above treatment: \_\_\_\_\_ Please initial appropriate boxes below

<b>The information to be used or disclosed includes:</b>	<b>Yes</b>	<b>No</b>
Social, medical or psychological reports		
Medication(s) used in treatment		
Treatment goals and results		
Information about drug and/or alcohol abuse		
School records		
Police, court or probation records		
Verbal Consultation		
Other (specify):		
<b>This information disclosure is necessary for the following purpose(s):</b>	<b>Yes</b>	<b>No</b>
Diagnosis and evaluation		
Continuity and coordination of care		
Completion of historical information		
Evaluation of medication		
Custody/parenting time evaluations		
Parent Coordination		
Other (specify):		

If we are requesting this Authorization from you or your child for our own use and disclosure or to allow another health care provider or health plan to disclose information to us: (1) We cannot deny our services or treatment to you or your child if you or your child refuse to make this signed authorization; however, we cannot complete an accurate evaluation if there is a refusal; (2) You or your child may inspect a copy of the protected health information to be used or disclosed, unless this inspection is not in your child's best interests; (3) You or your child may refuse to sign this Authorization; however, we cannot complete an accurate evaluation if there is a refusal; and (4) We must provide you or your child with a copy of the signed Authorization. You or your child have the right to revoke this Authorization at any time, provided that you or your child do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. **Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.**

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected under federal law.

\_\_\_\_\_  
(Date) \_\_\_\_\_ (Signature of Client) (or)

\_\_\_\_\_  
(Date) \_\_\_\_\_ (Signature of Person Authorized by Law/Relationship to Client)