AUTHORIZATION OF CHARLENE SABIN, MD, TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize:

Name of Doctor/Hospital/Therapist/School: _____
Address of Doctor/Hospital/Therapist/School: _____
_____
Phone/Fax of Doctor/Hospital/Therapist/School: _____

Is this Doctor/Hospital/Therapist/School: A current provider _____ A previous provider _____

to disclose and/or receive a copy of the entire health or educational record of:

Client's Name: _____ DOB: _____
for the purpose of therapy/medical treatment/parent coordination/custody evaluation. Records should be sent to:

Charlene Sabin, MD
5441 S Macadam Ave., #200
Portland, OR 97239
503-282-6448 Phone
503-282-6473 Fax

I further authorize Dr. Sabin to gather and/or provide information through direct conversation with the above named individual or representative.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed **if I place my initials in the applicable space next to the type of information**.

_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

ADDITIONAL INFORMATION

You do not need to sign this Authorization to receive non-court ordered services. Refusal to sign the Authorization will not adversely affect your ability to receive health care services or reimbursement for services. Refusal to sign means you will not receive health care services if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Services such as custody evaluations, parent coordination and court ordered family therapy require signing Authorizations as specified in the relevant court order.

This Authorization will remain in effect for one year unless revoked. You may revoke this Authorization in writing at any time. If you revoke your Authorization, the information described above may no longer be used or disclosed for the purposes described in this written Authorization. The only exception is when a covered entity has taken action in reliance on the Authorization or the Authorization was obtained as a condition of obtaining insurance coverage.

To revoke this Authorization, please send a written statement to Charlene Sabin, MD, 5441 S Macadam Ave., #200, Portland, OR 97239 and state that you are revoking your Authorization.

SIGNATURE

I have read this Authorization and I understand it. This Authorization will remain in effect for one year from the date of signing or:

_____ Until I revoke it in writing
_____ Until _____ (list specific date)
_____ Until the following event occurs: _____

By: _____ Date:_____
(Individual or personal representative)

By: _____ Date:_____
(Individual or personal representative)

A photocopy of this authorization has the full force and effect as the original.