OtterWell
Mental Health LLC

https://otterwellmentalhealth.com

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1336 NW Flanders Street #143 Portland, Oregon 97209

AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)

Client Information

Name: _____Date of Birth: _____

Phone Number: _____

This form allows your provider and OtterWell Mental Health LLC to share or receive information with another person or organization listed on this form. You have the right to decide what can be shared, with whom, and for how long. Signing this form is voluntary.

Person/Organization Involved In Release

I authorize Stephanie Schaefer, Psy.D. and OtterWell Mental Health LLC to (select **ONE**):

[ ] Release information to the individual or organization listed below:

[ ] Receive information from the individual or organization listed below:

[ ] Both release and receive information to and from the individual or organization listed below:

Name/Organization: _____

Information To Be Released/Exchanged

The following information may be released/exchanged (select all that apply):

[ ] Entire clinical record

[ ] Intake/initial evaluation report

[ ] Reports

[ ] All Treatment/therapy progress notes

[ ] Treatment/therapy progress notes for these specific dates:_____

[ ] Treatment summary

[ ] Treatment plan(s)

[ ] Diagnosis/diagnoses

[ ] Session attendance only

[ ] Billing/insurance information

[ ] Discharge summary

[ ] Other (please describe): _____

Purpose Of Release

The above information will be used for the following purposes (select as many as apply):

[ ] Continuity of care/treatment planning

[ ] Coordination of care

[ ] Insurance or payment purposes

[ ] Legal or court-related purposes

[ ] School/workplace accommodations

[ ] Emergency Contact

[ ] Determining eligibility for benefits or programs

[ ] Updating files

[ ] Case review

[ ] Other (please describe): _____

Expiration of Release

This authorization will expire upon termination of treatment. You may revoke this authorization in writing at any time. Revoking this authorization will not apply to any information that has already been released.

Rights & Consent

- Signing this form is voluntary. Your treatment may not be conditioned on my signing this document.
- I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a healthcare provider covered by state or federal rules.

- Confidentiality cannot be guaranteed once the information has been shared outside of OtterWell Mental Health LLC.
- You have the right to inspect or obtain a copy of the information being released.

Client Signature: _____Date: _____

Your relationship to client (select **ONE**):

[ ] Self [ ] Parent/legal guardian [ ] Personal representative [ ] Other (specify):_____

Psychologist Signature: _____

Date: _____

ROI Revocation Date:_____