CHILD AND FAMILY PSYCHIATRIC CENTER
1744 E. McAndrews Rd., Suite B ▪ Medford, Oregon 97504
Phone (541) 776-0821 FAX (541) 776-5011
www.childandfamilypsychiatriccenter.com

AUTHORIZATION TO USE/DISCLOSE MENTAL HEALTH INFORMATION

I authorize: ☐ DR. CALLANAN ☐ PAMELA RIVERA, PMHNP ☐ HECTOR ALEMAN, LCSW

☐ W. DEVIN SMITH, PMHNP ☐ JULIE NEWMAN PMHNP ☐ JACK OPGENORTH, LCSW

of Child and Family Psychiatric Center to use/disclose and furnish/receive a copy of my specific Mental Health information described below regarding:

Patient Name _____ Date of Birth _____

Consisting of: Psychiatric Evaluations _____ Progress Notes_____ Verbal _____
Medications _____ Billing _____

Other (specify) _____

_____

to/from _____
(Name of Recipient) (Phone) (FAX)

_____
(Address)

for the purpose of : ☐ Continuation of Treatment ☐ Other (specify) _____

PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign this Authorization in order to receive treatment.
- I understand that I may revoke this Authorization, at any time, provided I do so in writing and except to the extent that CFPC has already used or disclosed the information in reliance to this Authorization.
- This Authorization is to remain in effect throughout the duration of my treatment, unless revoked earlier.
- I have a right to a copy of this Authorization.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release CFPC from all legal responsibilities and liabilities that may arise from the release of such protected health information

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____
Signature of Patient Date Parent / Authorized Person Date

_____
Relationship to Patient