2236 SE Belmont Street • Portland, Oregon • 97214
Phone: 503-445-7699 • Fax: 503-802-0199
prismhealth.org

MENTAL HEALTH RELEASE OF INFORMATION Date: _______________

CLIENT INFORMATION			
Last Name:	First Name:		Middle Initial:
Address:		Apt:	Date of Birth:
City:	State:	ZIP:	Phone:
I authorize Prism Health to: ◻ OBTAIN information from ◻ DISCLOSE information to			
Facility or Provider Name:			
Address:			Phone:
City:	State:	ZIP:	Fax:

INFORMATION TO BE DISCLOSED

Please check the type(s) of mental health information you want released:
◻ Mental Health Assessment ◻ Treatment Plan ◻ Progress Notes ◻ Safety Plan ◻ Discharge Summary
◻ ALL mental health records ◻ Other: ___________________________________

PURPOSE FOR DISCLOSURE/COMMUNICATION

◻ Emergency ◻ Coordination of care with other provider ◻ Insurance claim ◻ Legal purposes
◻ Social Security Disability ◻ Personal use ◻ Other: ____________________________________

I understand that additional laws about mental health, HIV/AIDS, genetic, and substance use treatment information may apply. I understand and agree that this information may be disclosed if I place my initials in the applicable space.

Initial: _____ Mental Health Information	Initial: _____ Substance Use Treatment
Initial: _____ HIV/AIDS Information	Initial: _____ Genetic Testing Information

RELEASE AND EXPIRATION OF ROI

This Release of Information will expire after 12 months from the date it was signed. If you would like this Release of Information to expire sooner than 12 months, please specify the date you would like to expire: ___________________

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. This authorization may include disclosure of information relating to mental health treatment, substance abuse treatments, and HIV/AIDS related information unless I indicated otherwise. I understand that this Release of Information will expire 12 months from the date it is signed unless I indicated otherwise. If at any time I change my mind and want to revoke this Release of Information, I must contact Prism Health in writing to make the request. This form is not valid unless it is signed at dated by the patient.

___________________________________	___________________________________	_________________
Client Printed Name	Client Signature	Date
___________________________________	___________________________________	_________________
Parent/Guardian Printed Name	Parent/Guardian Signature	Date