JASPER MOUNTAIN AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize (Source of Information): ____

to disclose a copy of the health and clinical information indicated below to Jasper Mountain, regarding:

Client's Name: ____ **D.O.B.** ___________

consisting of: ____

____ **and including (please INITIAL↓):**

PLEASE INITIAL

___ **Yes** ___ **No** **Family History**	___ **Yes** ___ **No** **Mental Health Services**
___ **Yes** ___ **No** **Employment/Unemployment**	___ **Yes** ___ **No** **Medical/Psychiatric Treatment**
___ **Yes** ___ **No** **Educational Reports**	___ **Yes** ___ **No** **Labs/Diagnostic Tests**
___ **Yes** ___ **No** **Alcohol/Drug Treatment (Minor)**	**Other:** ______________________

Note: Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

Please send to the indicated Agency location:	☐ **Jasper Mountain Center** 37875 Jasper-Lowell Road Jasper OR 97438 **Fax: (541) 747-4722** Phone: (541) 747-1235
	☐ **SAFE Center** 89124 Marcola Road Springfield OR 97438 **Fax: (541) 726-9869** Phone: (541)741-7402

Purpose of Release: The information received will be used by the Jasper Mountain programs to evaluate the child's situation and to plan for/coordinate services for the child and family, or for other purposes as specified.

Mutual exchange allowed? PLEASE INITIAL ➔ **Yes** _____ **No** _____ **Not Applicable** _____

Individual Authorizing Release: ____

Above listed individual's relationship to client granting authority to sign this release:

☐ **Parent** ☐ **Other Guardian** ☐ **Other (*describe*):** ____

____

TO THE INDIVIDUAL AUTHORIZING THIS RELEASE: The above named child's health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless the child's health care or treatment is for the purpose of 1) creating health information about the child to be disclosed to a third party; or 2) for the purposes of research. You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, our agency will no longer use or disclose information about the named child for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a signed and dated written statement to Privacy Officer at Jasper Mountain, 37875 Jasper-Lowell Road Jasper OR 97438, identifying the date you signed this authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. By signing this authorization, you are directing the above listed entity to disclose health information to another organization that may or may not have or obey the same obligations to protect privacy under state and federal law. Therefore, the disclosure specified above carries with it the potential for an unauthorized redisclosure and loss of protection under state and federal law.

This Authorization is effective on _____________ and is good for 90 days unless it is revoked. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and loss of protection under state and federal law. ***I have reviewed and understand this Authorization. By signing below, I so authorize this release:***

Signature: ____ **Date:** ____________________