Autumn Leaf Therapeutic Services
be what you might have been

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Authorization of Consent to Release Information

I, _____, DOB:_____ authorize **Autumn Leaf Therapeutic Services** to:

_____ Discuss (verbally or in writing) my care
_____ Send or receive records with any person/s or staff of clinic, office, agency, or institution/s named below:

Person, Clinic, Hospital, or Provider Group: _____
Phone Number and/or office location: _____
Person, Clinic, Hospital, or Provider Group: _____
Phone Number and/or office location: _____
Person, Clinic, Hospital, or Provider Group: _____
Phone Number and/or office location: _____
Use back of form for additional release parties. Initial and date all additions.

To include:
_____Medical Records
_____Mental Health/Psychological/Psychiatric Services
_____Addiction/Substance Use
_____Infectious Disease (including HIV/AIDS)
_____Genetic Testing

From dates: _____ to _____

Please send records to:
□ Mailed (Paper Copy: Fees apply) to the following address:
_____
□ Fax (No Charge)
□ Electronic to email (Fees apply): _____

For the following purpose(s):
□ Continuity of Care □ Personal Records □ Legal □ Other: _____

I may revoke this consent at any time. This consent is in effect for **two years** from the date of the last session, unless revoked in writing earlier or renewed. I understand that the information used or disclosed as stated in this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. Autumn Leaf Therapeutic Services is not responsible for any breach of information by recipients of records.

_____ _____ _____
Name (print) Date Signature

Records Processing Costs (All within *ORS 192.521 Health care provider and state health plan charges)*. Printed records are: $8.70 for Priority Mail Flat Rate Envelope (with Tracking) and $0.50 for pages 1-50, $0.25 for pages 51+. Secure file transfer online of PDF of records is a flat fee of $15 regardless of size of the record.