



Jean Thompson Vanlue, LLC

**Jean Thompson Vanlue, M.A., LPC, LMFT
528 Cottage St. NE, Ste. 300, Salem, OR 97301
503-316-9130**

Authorization for release of information

Name: _____ DOB: _____

I authorize Jean Vanlue, MA, LPC, LMFT to use and disclose a copy of the specific health information described below and I authorize an exchange of said confidential information between and:

Name: _____

Address: _____

Phone: _____

This information will be used on my behalf for the following purpose(s): _____

By **initialing** below, I specifically authorize the release of the following medical records:

- | | |
|---|---|
| _____ Chart Intake and Progress Notes | _____ HIV/AIDS Information |
| _____ Mental Health Services Summary | _____ Medical History & Physical Assessment |
| _____ All Records needed for continuity of care | _____ Psych. Assessment/Testing Information |
| _____ Billing/payment records | _____ Drug/Alcohol Diagnosis, Treatment, Referral |
| _____ Other _____ | _____ Genetic Testing Information |

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I understand that I do not need to sign this authorization and that refusal to sign will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign prohibits receiving health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

Unless revoked earlier, this authorization will be in effect for the duration of my treatment with Jean Vanlue, MA, LPC, LMFT. I may revoke this authorization at any time by a written request to Jean Vanlue. If I revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has already taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

My signature indicates that I understand the above and consent to disclose indicated information.

Individual or Personal Representative Signature

Date

Personal Representative authority: _____

To those receiving information under this authorization: This information is protected by State and Federal Law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws. Rev. 8/15