Teresa Heesacker Counseling
Teresa Heesacker, MA, CSD, LPC, LMFT, RPT
1308 E. First Street, Newberg, OR 97132
503-610-3499
teresa@heesackercounseling.com
www.heesackercounseling.com

Authorization to Use and Disclose Protected Health Information

By signing this form, I authorize the person/organization listed below to disclose indicated confi denti al information regarding me and my situation.

Client name:_____ Date of Birth: _____

Person/Organization: _____ e-mail: _____

Address: _____Phone:_____

Type of information to be released (genetic testing information never disclosed):

☐ alcohol / drug ☐ mental health / medication ☐ HIV / AIDS ☐ billing

Any specific information you DO NOT want disclosed: _____

I authorize Teresa Heesacker Counseling to :
☐ Both Release and Receive Information ☐ Release Information Only ☐ Receive Information Only

Information will be used on my behalf for the following:
☐ assessment ☐ treatment ☐ referral ☐ care coordination ☐ monitoring ☐ payment

Federal Law (42 CFR part 2) or State law (ORS 433.045, 179.505, 344.600, OAR 333-22-0210) may require HIV/AIDS, mental health, drug/alcohol information not be re-disclosed. It is possible that the individual or organization that received the information may re-disclose it. Re-disclosure is done solely through the written consent of the person to which the information pertains. The information being disclosed, via a true copy of the original authorization, will be the minimum amount necessary to serve the intent of this authorization.
I understand information may be shared via telephone, fax, e-mail, written or in person.

This authorization can be made void, verbally or in writing, at any time. Disclosures prior to voiding can not be undone. I understand I am not required to sign the authorization. Refusal to sign will not affect access to care. This authorization will remain in effect for 60 days after the duration of treatment.

I have read, or have had this authorization read to me, understand it and agree to these terms and conditions.

_____
Full legal signature of individual or authorized personal representative Relationship to client Date

_____
Full legal signature of individual or authorized personal representative Relationship to client Date

_____
Teresa Heesacker, MA, CSD, LPC, LMFT, RPT Counselor Date