SEQUOIA
MENTAL HEALTH SERVICES, INC.

AUTHORIZATION FOR EXCHANGE / RELEASE OF INFORMATION

Please send information to the following address:

☐ Aloha Clinical Office: 4585 SW 185th Avenue, Aloha, OR 97078. Phone: 503-591-9280 Fax: 503-848-2072
☐ Hillsboro Clinical Office: 395 W Main Street, Hillsboro, OR 97123 Phone: 503-213-1302 Fax: 503-648-9732
☐ Rosewood RTH: 1615 22nd Avenue, Forest Grove, OR 97116 Phone: 503-941-5236 Fax: 503-941-5157
☐ Edwards RTF: 4180 SW 185th Avenue, Aloha, OR 97078 Phone: 503-649-4925 Fax: 503-591-5602
☐ Myrtlewood RTH: 20695 SW Kinnaman Drive, Aloha, OR 97078 Phone: 503-591-8371 Fax: 503-356-8327
☐ Juniper RTH: 426 SE 6th Avenue, Hillsboro, OR 97123 Phone: 503-530-8170 Fax: 503-430-1316
☐ Myrtlewood RTH: 1775 SW 87th Avenue, Portland, OR 97225 Phone: 503-265-8565 Fax: 503-265-8561

Name: _____DOB:_____

I authorize Sequoia Mental Health Services to exchange information with:

_____

Name Address Phone

The following information may be released:

☐ Psychiatric/Mental Health
☐ Physical Health
☐ Lab Reports
☐ Urinalysis (Including Substance Use Info)
☐ Medication Information
☐ History and Assessments
☐ Progress Notes/Visit Notes
☐ Financial
☐ Legal
☐ Discharge Summary
☐ Other: _____

Special Release Disclosures **TO RELEASE THESE MUST BE INITIALED:**

_____ HIV/AIDS Status

_____ Substance use diagnosis, treatment or referral

*****Information may include Substance Use Disorder Diagnosis, Treatment, and Referral Information.*****

For the following purpose: ☐ Case coordination and/or _____
☐ At the request of the client

I understand that my records are protected under the federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance of this release, and that in any event, this release expires automatically one year from execution date below. You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive 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.

Executed this ___ day of _____, 20___.

This information has been disclosed to you from records whose confidentiality is protected by federal law. A federal regulation prohibits you from further disclosure without the signed consent of the individual or as otherwise permitted by the regulations. Sequoia Mental Health Services cannot be responsible for further re-disclosure of information given to another party. This disclosure is not protected by the Privacy Rule.

_____
Signature of Client

_____
Signature of Witness

_____
Signature of Parent/Guardian if required