Administrative Office
(541) 523-7400
Fax: (541) 523-4927
2100 Main Street, P.O. Box 1005
Baker City, OR 97814
www.newdirectionsnw.org

Chief Executive Officer: Shari Selander

New Directions for Positive Changes….
"Specializing in helping people with Alcohol, Drug, and Gambling Addictions, Mental Health, Developmental Disabilities and Prevention."

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I____, DOB________________authorize New Directions Northwest, Inc. to contact:

____

(Person or agency to and/or from whom NDN may receive and/or disclosed my protected health information)

KIND OF INFORMATION: (Initial one or more)

- ☐______ Mental Health Assessment
- ☐______ Mental Health Progress Notes
- ☐______ Mental Health Discharge Summary
- ☐______ Psychiatric Assessment
- ☐______ Psychiatric Progress Notes
- ☐______ MIP DUII Completion
- ☐______ Care Coordination
- ☐______ Education Records
- ☐______General Medical Records
- ☐_____ Substance Abuse Assessment
- ☐_____ Substance Abuse Progress Notes
- ☐_____ Substance Abuse Discharge Summary
- ☐_____ Developmental Disability Assessment
- ☐_____ Developmental Disability Progress Notes
- ☐_____ UA Screening
- ☐_____ Information necessary to Arrange Transportation
- ☐_____ Information Necessary to Deal with an Emergency
- ☐_____ Information about HIV/Aids related testing
- ☐______ Other: ____
- ☐______ Other: ____

FOR THE PURPOSE OF: (Initial on or more)

- ☐______To assess eligibility and need for treatment
- ☐_____ To plan and coordinate treatment
- ☐______ UA
- ☐______MIP/DUII
- ☐_____ Coordination of Care
- ☐______Other: ____
- ☐______Other: ____

TERM OF THIS AUTHORIZATION

By initialing one of the lines below, I specifically authorize disclosure, receipt and use of the type of information indicated above by my initials for the term I have checked and initialed below. I understand that I can revoke this authorization at any time by notifying New Directions Northwest, Inc. in writing of the revocation. I understand that revoking this authorization will not affect information that has already been disclosed, received or used by New Directions Northwest, Inc. and/or the party or parties from or to whom it was received or disclosed.

This authorization will remain in effect:

- ☐____for one year from the date of this authorization.
- ☐____from the date of this authorization until ____________________
- ☐____until the following event occurs: _________________________
- ☐____other:____

I am:

- ☐The person whose protected health information by this authorization.
- ☐The Legal Guardian or Custodian of the person whoseis covered protected information is covered by this authorization.
- ☐The Parent of the minor child is protected Health information is covered by this authorization
- ☐Authorized to sign by a currently valid health care Power of Attorney.

I have read and understand the terms of this Authorization to Disclose, Receive and Use Protected Health Information. By my signature below, I voluntarily authorize disclosure, receipt and use of my protected health information as indicated above. I can revoke it at any time by notifying New Directions Northwest, Inc. in writing.

Printed Name of Authorizing Person	Signature of Authorizing Person	Date Signed
Printed Name of Witness	Signature of Witness	Date Signed

Authorization **REVOKED on:** ____________ ☐**Verbally** ☐**in Writing** **Staff Signature** ______________________