SHERYL MOREN, PMHNP-BC, LLC
Psychiatric Mental Health Nurse Practitioner
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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ [client's name] _____ [client's date of birth],
give permission to Sheryl Moren, PMHNP-BC, LLC, 2029 SE Jefferson St., Suite 101, Milwaukie, OR 97222, to **(initial by all that apply)**:

_____ Disclose/send records to:
_____ Exchange health information with:
_____ Receive health records from:

Name(s):_____
Address: _____
City, State, & Zip Code: _____
Phone: _____ Fax: _____

This protected health information is being used or disclosed for the following purposes **(initial by all that apply)**:

_____ Continuation of mental health care
_____ Coordination of care
_____ Insurance claim
_____ Other (specify): _____

To include **(initial all that apply)**:

_____ All information in chart
_____ Specific chart information: _____

Health information to be disclosed **(initial by all that apply):**

_____ Mental health records
_____ Medical records
_____ Laboratory reports
_____ Genetic testing information
_____ HIV/AIDS related records
_____ Drug/alcohol diagnosis, treatment, or referral information
_____ Other (specify): _____

The scope of information authorized for release involves records covers **(initial by all that apply):**

_____ All dates of service
_____ Service between _____ and _____

Unless revoked, this authorization expires in **one year** or upon (insert date or event) _____ .

I understand that any information that is exchanged with another person will be protected if that person is required to comply with the Federal Privacy rule. If privacy laws do not apply, the information may not be protected and could be re-disclosed without authorization.

I understand that I may refuse to sign this authorization at any time. My refusal to sign will not prevent me from receiving mental health services or reimbursement for services. The only exception is if the services are solely for the purpose of providing information to someone else and this authorization is necessary to make that disclosure.

I understand that I may revoke this authorization at any time. If I revoke this authorization, it is no longer valid. The only exception is when the authorization was obtained as a condition of obtaining insurance coverage. However, any information exchanged before I revoke this authorization cannot be retrieved. To revoke this authorization, please send a written statement revoking this authorization to: Sheryl Moren, PMHNP-BC, LLC at 4207 SE Woodstock Blvd #286, Portland, OR 97206.

I may inspect or copy any information used and/or disclosed under this authorization. Sheryl Moren, PMHNP-BC, LLC, an independent practitioner, is not responsible for the cost of copies.

I have read this authorization and I understand it. This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

_____ _____
Printed Name of Participant (or Personal Representative)

_____
Description of Personal Representative's Authority