PETER A. POWERS, PH. D., LLC
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Authorization Form

***Initial** where 'X' indicated and **Sign and Date** Below*

I____, date of birth ____________________________
(Name of client)

Authorize, Peter A. Powers, Ph.D. to:

x_____**EXCHANGE** ________ **OBTAIN** ________**RELEASE ONLY**
My personal and protected health and mental health information with/from/to:

Name: __________________________________ Telephone: __________________Fax:____________________

By ***initialing*** the spaces below, I specifically authorize the disclosure of the following health records:

x_____Session/Medical Chart Notes _____Evaluation Results _____Recommendations _____Treatment Summary

_____Substance Use Information _____ HIV status _____ Other (specify):________________________________

I am requesting that Peter A. Powers, Ph. D. exchanges/releases this information for the following reason(s):

x_____Coordination/Continuity of care _____Evaluation ____or for (specify):_____________________________

Your rights: Your signature on this Authorization cannot be required to receive your health care and payment for that health care, unless the health treatment is for the purpose of: (1) Creating health information about you to be disclosed to a third party; or (2) For the purpose of research.
You have the right not to sign this Authorization. You have the right to revoke this Authorization at any time. If you revoke your Authorization, we will no longer use or disclose the above information about you, but we cannot take back any disclosures already made with your permission. To revoke this Authorization, please send a written statement to Peter A. Powers, Ph. D. (at 511 East 12th Avenue Eugene, OR 97401), that identifies the date of this Authorization and the recipient of the information listed in this Authorization, and state that you are revoking this Authorization. This Authorization shall remain in effect until a designated time period passes or an event occurs or if left blank for one year from the date signed below. Time Period: ________________ Event: _____________________

I have reviewed and I understand this Authorization. By signing this Authorization, I am directing my health care provider to disclose my health information to another person or organization that may not have to obey the same obligations to protect privacy under state and federal law. Therefore, **the disclosure of the information specified above carries with it the potential for unauthorized redisclosure** and loss of protection under state and federal law.

By____ Date:____________________
(client signature)

By____ Date:____________________
(client representative, if minor)
Description of Representatives Authority:____