EUGENE PSYCHOLOGICAL ASSESSMENTS

RELEASE OF INFORMATION
(ROI)

Client (the person to be tested)

Name _____

Date of Birth _____

I hereby authorize:

☐ Eugene Psychological Assessments /

☐ Dr. Gretchen Scheidel
☐ Dr. Jennifer Hogansen

…and the Person/ Organization/ Agency named below to fully exchange: patient medical and clinical information relating to treatment, with social, medical, psychological, psychiatric histories and diagnoses, treatments, prognoses, counseling/ therapy, and/or school work notes contained in the patient records:

Person/ Org. _____

Relationship to client _____

Street address _____

City, State _____

Phone number _____

Fax number _____

Email _____

Please release the following information for the purpose(s) of:

☐ ALL of the purposes listed below:

☐ Referral
☐ Continuity of care
☐ At the request of the patient or legal/personal representative

☐ All health records from the above-named entity:

- ☐ Discharge Summary
- ☐ Physician Orders/ Progress Notes
- ☐ Dietetic Orders/ Progress Notes
- ☐ History/ Physical Examination
- ☐ Emergency Department records
- ☐ Laboratory/ Radiological Reports
- ☐ Psychological Testing
- ☐ Psychosocial History
- ☐ Psychiatric Orders/ Progress Notes
- ☐ Clinical/ Nursing Staff Progress Notes
- ☐ Medication Administration Records
- ☐ Billing statements
- ☐ Educational Records
- ☐ Other _____

☐ All Specially-Protected Information to include:

- ☐ Written
- ☐ E-mail (Electronic communication)
- ☐ Verbal (in person/ telephone /cellular phone)
- ☐ Fax

I understand that, if the recipient of the info disclosed under this authorization is not a health plan or provider covered by Federal or state privacy laws, the info may be re-disclosed by the recipient and no longer protected by those laws. If the info being disclosed under this authorization includes HIV/AIDS, Sexually Transmitted Diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, Federal or state law may prevent the recipient from re-disclosing this information.

I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for the purposes of research-related treatment, to determine my eligibility or enrollment in a plan for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purposes of providing that information to someone else.

I received a copy of this authorization. I may inspect/request copies of info this authorization discloses.

Unless revoked, this authorization is valid for one year. This consent is subject to revocation in writing by the undersigned at anytime. I have read this authorization, and I understand it.
You must sign and click "Submit Signature." Otherwise, this form is not valid.

Signature _____

Date _____