JAMES F. HALLEY

ATTORNEY AT LAW

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CONSENT FOR RELEASE OF RECORDS AND INFORMATION

I authorize _____ (provider) to release a copy of all information concerning me _____, to JAMES F. HALLEY, Attorney at Law, 735 SW First Ave., Second Floor, Portland, Oregon 97204 (phone 503-295-0301). By signature on this consent I waive, as to JAMES F. HALLEY, any otherwise applicable privilege.

This information will be used for the following purposes: LEGAL PROCEEDINGS.

The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record. I agree to reimburse the recipient for costs associated with producing these records.

By initialing the spaces below, I specifically authorize the release of the following records, if such records exists:

SECTION I

___ Please send the entire record (all information) regarding my mental or physical health.

SECTION II

ONLY the following:

___ All hospital records	___ Nursing care records	___ Clinician office chart notes
___ Transcribed hospital reports	___ Dental Records	___ Physical Therapy records
___ Most recent five year history	___ Pathology reports	___ Billing statements
___ Diagnostic imaging reports	___ Laboratory reports	___ Emergency and Urgency Care Records
___ Medical records needed for continuity of care		___ Other: _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information disclosed under this authorization.

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I understand that the person(s) I am authorizing to disclose my information may receive compensation for doing so.

SECTION III

___ HIV/AIDS- related records* ___ Genetic testing information* ___ Mental Health information*

___ **Drug/alcohol diagnosis, treatment or referral information, to be used for: _____

___ ***Psychotherapy notes

SECTION IV

___ Any and all other records, including but not limited to school records, employment and wage records, tax records, business or accounting records, insurance records, police records or reports.

This authorization may be revoked in writing at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete this request. A copy of this authorization shall serve as an original.

All other authorizations are hereby canceled. The provider is advised that they are not to release information to any other entity without written authority from me unless compelled to do so by operation of law.

Date: _____ _____
Signature

DOB: _____ _____
Print Name

SSN: _____

*Must be initialed to be included in other documents.
** Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.
***This authorization cannot be combined with any other authorization. If initialed, it must be the only authorization on the form.