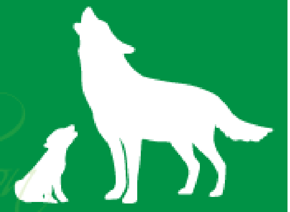
Wolf Pack
Consulting and Therapeutic Services, LLC
(p) 503.828.3402
(f) 503.828.3401
contact@wolfpackcts.org
healing through innovation and tradition



Authorization to Use/Disclose Health Information

Legal Name:	Preferred Name:	Date of birth:

I hereby authorize: Wolf Pack Consulting and Therapeutic Services, LLC
16365 NW Twin Oaks Drive Suite 200 Beaverton, OR 97006
All mail to: 16055 SW Walker Road #443 Beaverton, OR 97006
503.828.3402 (office), 503.828.3401 (fax)

To release information to ☐ and/or

To receive information from ☐

Person:	Organization:
Address:	
Phone Number:	Fax Number:
Email Address:	

I specifically authorize the release/exchange/receipt of the following information:

Mental Health Records Including:

(*Indicate by initialing*)

____ Identifying Information

____ Lab Records

____ Medical Records & X-rays

____ Mental Health Treatment Records

____ Psychiatric Evaluation(s)

____ Progress Notes

____ Discharge/Transfer Summary

____ Other (*specify*): ____________________________

Substance Use Disorder Records:

(*Indicate by initialing*)

____ Identifying Information

____ Lab Records/Urinalysis

____ Medical Records & X-rays

____ Substance Use Treatment Records

____ Psychiatric Evaluation(s)

____ Progress Notes

____ Discharge/Transfer Summary

____ Other (*specify*): ____________________________

I recognize that the information released may contain information regarding **mental health** treatment that is protected by state law (ORS 179.505 & 192.505, 45 CFR 205.50). I specifically consent to its release.

Signature: ___________________________________

Date: ______________________________________

I recognize that the information released may contain **drug/alcohol** information that is protected by federal and state law. [42CFR2.31, ORS 430.399(5) & 179.505]. I specifically consent to its release.

Signature: ________________________________

Date: ____________________________________

Purpose of such disclosure: *(Choose all that apply)*

☐ Treatment Planning

☐ Referral/Consultation

☐ Legal Issues

☐ Facilitate Health Benefit Utilization

☐ Diagnosis and Evaluation

☐ Coordinate Aftercare/Ongoing Treatment/Services

☐ Coordination of Care

☐ Other (*specify*): ______________________________

The individual signing this form agrees and acknowledges the following:

(i) Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
(ii) Effective Time Period: This authorization shall be in effect for one year after it is signed unless a specified termination date it requested: **Month: ________ Day: ________ Year: _________.**

(iii) Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

SIGNATURES:

Client/Legal representative: ____ Date:_________________________

If Legal representative, relationship to client: ____

ROI_WPCTS
Created: 06.01.2017
Revision: 05.18.2022