**Sue Ujvary, MS, LPC**
**1525 NE Weidler, Suite 101 - Portland, Oregon 97232**
**sujvary@comcast.net, 360-909-2489, fax: 503-296-5758**

RELEASE OF HEALTHCARE INFORMATION AUTHORIZATION (R.O.I.)

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I hereby authorize the following entity to release information to the office listed in the heading above:

Name of Provider _____

Address: _____

City: _____ State: _____ Zip Code: _____

Fax # _____ Phone # _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of my prescription medication history, including any and all pharmaceuticals, alternative medicines and naturopathic remedies to the person listed above.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.