***SYNERGY CO-PARENTING SOLUTIONS,LLC***

*Michael Alter, LCSW and Rena Fox, JD*

*PO BOX 80241*

*Portland, OR 97280*

# Ph: 813.702.0066

rfox@synergycoparentingsolutions.org

Client Names: DOB:

I authorize Synergy Co-Parenting Solutions, LLC to:

Receive my specific health information from the person(s) named below

Send my specific health information to the person(s) named below

with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to me/my child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize this information to be used for: (initial all that apply)**

Reunification Services Parenting Coordination

Other (*specify*)

**I authorize the exchange of the following information: (initial all that apply)**

Mental health session notes Custody evaluation reports and data

Mental health treatment summary School records

Psychological evaluation reports Police, court or probation records

\_\_\_\_\_\_Physical exam results and medication list Verbal summaries of information

\_\_\_\_\_\_Drug/Alcohol Diagnosis, treatment, or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed) Description:

**1.** I understand than any information that is exchanged with another person will be protected if that person is required to comply with the Federal Privacy rule. If privacy laws do not apply, the information may not be protected and could be re-disclosed without authorization. **2.** I understand that I may refuse to sign this authorization. My refusal to sign will not prevent me from receiving services or reimbursement for services. The only exception is if the services are solely for the purpose of providing information to someone else and this authorization is necessary to make that disclosure. **3.** I understand that I may revoke this authorization at any time by sending a written statement to Synergy Co-Parenting Solutions, LLC. If I revoke this authorization, it is no longer valid. The only exception is when the authorization was obtained as a condition of obtaining insurance coverage. However, any information exchanged before I revoke this authorization cannot be retrieved. This authorization will automatically expire when work with Synergy Co-Parenting Solutions, LLC is completed.

**I have read this authorization and I understand it.** This completed authorization must be signed by the client or a person authorized by law to represent the client. A copy of this authorization is as valid as the original.

**Signature of Client or Client’s Parent/Representative Date**

**Signature of Client’s Other Parent (If applicable) Date**