C. David Maxey, M.A.
Licensed Psychologist Associate

7145 SW Varns St Suite 105, Tigard, OR 97223
info@CDavidMaxey.com • CDavidMaxey.com
503-928-4182 • Fax: 503-926-6433

Regarding: _____
Client's (Child's) Name — Birthdate

I authorize C. David Maxey, M.A. to: ☒ provide information to: ☒ receive information from:

_____
Name — Phone

_____
Address — City, State ZIP

_____
email — Fax

for the purpose of: ☒ continuing care ☒ coordinating care ☒ evaluation ☒ treatment

_____
describe the purpose of disclosure

The specific health information to be used and disclosed consists of:
☒ consultation ☒ treatment summary ☒ psychological report ☒ developmental pediatric report or notes

_____
describe other information to be used and disclosed

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if the applicable space next to the type of information is marked.

Mark information to be disclosed

☒ mental health information
☒ drug/alcohol diagnosis, treatment or referral information
☐ genetic testing information
☐ HIV/AIDS information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of mental health information, genetic testing information, HIV/AIDS information, and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to C. David Maxey, M.A. and state that you are revoking this authorization.

email may not be secure and presents a significant risk to confidentiality. By having an email address on this form, I am requesting email communication, and I acknowledge that I am aware of the significant additional risks to confidentiality.

I have read this authorization and I understand it. Unless revoked, this authorization expires in one year.

I am: ☐ the child's parent ☐ the child's legal guardian ☐ the child (if 14 years old or older)

Signature: _____
Date

Your Name: _____