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

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

Regarding:

Client's Name _____ Birthdate _____

I authorize C. David Maxey, M.A. to:

☐ provide specific health information to: ☐ receive specific health information from:

Name _____ Phone _____

Address _____

email _____ Fax _____

for the purpose of: ☐ continuing care ☐ coordination of care ☐ evaluation ☐ my personal reasons and request

_____
describe the purpose of disclosure

The specific health information to be used and disclosed consists of:

☐ consultation ☐ treatment summary ☐ psychological report ☐ educational report

_____
describe the 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 I place my initials in the applicable space next to the type of information.

Initial information to be disclosed

_____ mental health information _____ genetic testing information

_____ drug/alcohol diagnosis, treatment or referral 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.

Electronic communication by email or fax may not be secure and presents a significant risk to confidentiality. By placing an email address or fax number in the applicable space above, I am requesting electronic 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 on July 1st of the year after I sign this document.

Client's Signature _____ Date _____
(required if 14 years old or older)

Representative's Signature _____ Date _____ Representative's Name _____ Representative's Authority _____
(Parent or Guardian)