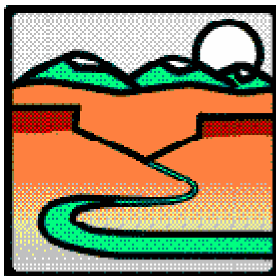

Rimrock Trails Adolescent Treatment Services
www.rimrocktrailsats.com
Residential & Outpatient Main Campus: 1333 NW 9th St., Prineville, OR 97754 – (541)447-2631
Redmond Outpatient Office: 413 SW 8th St., Redmond, OR 97756 – (541)617-4771
Bend Outpatient Office: 1010 NW 14th St, Bend, OR 97701 (541)388-8459
Toll Free: 1-888-532-6237

Authorization for Release of Information

To our clients: We can help you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations/individuals to share information about your situation.

Client's Name: _________________________________ DOB: ______________________ CPMS#: _______________

I authorize the following individual or agency:

to provide information to and obtain information from Central Oregon Extended Unit for Recovery dba: Rimrock Trails Adolescent Treatment Services, Main Campus 1333 NW 9th St. Prineville, OR 97754 - Bend Office 1010 NW 14th, Bend, OR 97701 541.388.8459 – Redmond Office Becky Johnson Center 413 SW 8th St. phone 541.617.4771

Including records of: (yes answers must be initialed to be valid)

☐ Yes ________ ☐ No Family History
☐ Yes ________ ☐ No Employment/Unemployment
☐ Yes ________ ☐ No Educational Reports
☐ Yes ________ Other as listed:
☐ Yes ________ ☐ No Mental Health Services
☐ Yes ________ ☐ No Medical/Psychiatric Treatment
☐ Yes ________ ☐ No Alcohol/Drug Treatment

Alcohol/Drug, Mental Health and Medical Records that include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

I agree that agencies and/or individuals listed above may share and exchange information about my family and circumstances. The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified:

I understand this permission is good for one year or until: / /

I can cancel at anytime, but I understand that the cancellation will not affect any information that was released prior to the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means, and I am signing on my own and have not been pressured to do so.

Client Signature:_____________________________________ Date:_________________________

Parent/Guardian Signature:____________________________________ Date: ________________________

Witness Signature:___________________________________ Date:_________________________
Admission Staff

To those receiving information under this authorization: This information has been disclosed to you from records whose confidentially is protected by Federal Law. Federal Regulations (42Cfr, part 2) prohibits you from making any further disclosers of it without the specific written consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.