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BHC Student Release of Information

At Orchid, we understand the significant role school plays in a child/adolescent's life. To ensure the highest level of wrap-around care, Orchid Health's Behavioral Health Clinicians routinely collaborate with students and school personnel. This collaboration is solely for treatment planning, school accommodations, behavior plans, clarifying diagnoses, and information only, as it relates to the behavioral, mental, and emotional health of the patient/student. Signing this document gives consent for two-way communication relevant to the individual care between the patient/student's Behavioral Health Clinicians and School. This also grants permission for Orchid Health's Behavioral Health team (including interns) to conduct visits with students within the school if services are desired.

I _____, Authorize Orchid Health to share and discuss information with:
Patient's Name/Parent and/or Guardian Name

- All students under the age of 14 MUST have a parent or guardian signature

School Name: _____ School District:_____

Address:_____ City, State, Zip: _____

Description of Information to be Disclosed

** Patient to **initial** each item to be disclosed **

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Info
_____ Presence/Participation in Treatment
_____ Nursing/Medical information

____ Educational Information
____ Discharge/Transfer Summary
____ Continuing Care Plan
____ Progress in Treatment
____ Demographic Information
____ Psychotherapy Notes**
____ Other _____
____ Do NOT share info with school personnel
** Cannot be combined with any other disclosure

Purpose of Release:_____

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By signing below, I acknowledge I am comfortable with Orchid Health's Behavioral Health Clinicians discussing the information initialed above with school counseling staff as needed. I also give permission to Orchid Health' s Behavioral Health Clinicians to discuss information with other school staff (teacher, principal, etc)_____

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

Patient Name: _____ Patient Contact Phone: _____

Current Address _____ D.O.B. _____

City, State, Zip _____ Email address: _____

Orchid Health Clinics:

Wade Creek Clinic: *535 NE 6th Ave, Estacada OR 97023* ***Phone:*** *503.630.8550* ***Fax:*** *503.630.8551*
Oakridge Clinic: *47815 HWY 58, Oakridge OR 97463* ***Phone:*** *541.782.8304* ***Fax:*** *541.782.5823*
McKenzie River Clinic: *54771 McKenzie Hwy, Blue River OR* ***Phone:*** *541.822.3341* ***Fax:*** *833.905.2303*
Fern Ridge Clinic*: 24934 Fir Grove Ln. Elmira, OR 97437* ***Phone:*** *541.234.3255* ***Fax****: 541.508.4135*
Sandy Clinic: *37400 Bell St, Sandy OR 97055* ***Phone:*** *971.220.2701* ***Fax:*** *503.210.8681*

Type of Information To Be Released: Information that is initialed above.

This authorization will expire one year from the date of the signature below. I understand that I can change my mind about this authorization at any time by writing to Orchid Health, but that any information already transferred will remain in Orchid Health's Confidential Medical Record System.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Orchid Health may redisclose the information if it is relevant for consultation, or if you request we transfer your records to another location.
- I am allowed to ask for and receive a copy of this Authorization.

Signature (from legal guardian if under age 14) _____ Date _____

Relationship to Patient: _____ Expires (1 year from date signed)_____

Clinic representative to initial when complete (if applicable)

_____ upload into patient confidential medical record system complete