7770 SW Mohawk St., Building F
Tualatin, OR, 97062
www.rosecitytherapeutics.com

AUTHORIZATION TO REQUEST OR DISCLOSE PROTECTED HEALTH INFORMATION

Completion of this form will serve as written permission for the Rose City Therapeutics practitioners that you indicate to communicate with the individuals you list below, only in the manner you specify. This authorization will be considered valid throughout the course of treatment unless otherwise requested by the client and/or guardian(s).

Client Name: ______________________________ **Date of Birth:** ____________________

I authorize release of information between (please indicate your practitioner(s) at Rose City Therapeutics):

☐ **Jams Markovics, Neurocounselor**
Rose City Therapeutics LLC
971-224-4089
drjams@rosecitytherapeutics.com

☐ **Carol Markovics, Clinical Psychologist**
Carol B. Markovics, Ph.D., LLC
503-563-5438
dr.carol@me.com

And the following individuals:

Name and Relationship or Title	Contact Information	Shared Information May Include:
____________________	______________________________	☐ **No restrictions**, all information relevant/pertinent to coordinating client treatment
____________________	______________________________	***- OR -***
____________________	______________________________	☐ Session notes only
____________________	______________________________	☐ Evaluation reports only
____________________	______________________________	☐ Informal progress updates only
____________________	______________________________	☐ Other: ______________
____________________	______________________________	______________________

Communication to/from these individuals may occur in a variety of ways (in person, phone, email, fax, etc.). Please know that you have the right to restrict how information about you or your child is shared. Kindly indicate any restrictions you wish to request regarding how information about you or your child is shared with the above named individuals:

☐ I do not have any restrictions on how information is shared.

☐ I wish to apply the following restrictions (i.e., phone calls only, no emails, etc.): ______________________

____

Client/Guardian Signature: ______________________________ **Date:** ________________

Printed Name/Relationship to client: ____