Office:_____

Address:_____

Phone:_____

Fax:_____

Authorization for Use and Disclosure of Individual Information

Legal Last Name of Individual:	First name:	MI:	Date of Birth:
Other names used by Individual:			

By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:

RELEASE FROM (Record Holder)

Record Holder's Identity (medical or other provider, agency, individual):
Full Name:_____ Address:_____

City, State and ZIP:_____

Email address:_____

Phone number:_____ Fax:_____

Specific information to be disclosed (Checked boxes indicate the information is authorized to be released) or detail here:
_____
(include date range if applicable):

- ☐ Psychiatric evaluation
- ☐ Medical and psychosocial history
- ☐ Psychological testing
- ☐ Assessment
- ☐ Appointment dates / Attendance
- ☐ Treatment plans
- ☐ Diagnosis
- ☐ Progress notes/ summary
- ☐ Medical exams
- ☐ Discharge summary
- ☐ Medication prescribed
- ☐ Lab/urinalysis result
- ☐ Billing records
- ☐ HIV/AIDS

Date(s) range:_____

Specially protected information: If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information: INITIAL EACH

___ Mental Health (except psychotherapy notes)
___ Genetic testing information
___ Alcohol/drug diagnoses, treatment, referral
___ HIV/AIDS information

Purpose of Disclosure:
☐ Continuity or care coordination ☐ Legal ☐ Insurance ☐ Other (please be specific)
_____

RECIPIENT/ RELEASE TO:

Name of agency, facility or specific person	Relationship:
Address:	Phone: Fax:
Expiration date or event:	Mutual exchange: ☐ Yes ☐ No

ACKNOWLEDGEMENT

This authorization remains in effect for one year after the last service, unless revoked or unless specified by this date or event above.

- I was given the opportunity to ask questions about this form and what it does.
- I understand that I can revoke (cancel) this authorization at any time and revocation (cancellation) will not apply to any information already disclosed or released. Except for drug and alcohol information, the individual or a person legally authorized to act on behalf of the individual is required to submit the cancellation request in writing to the Privacy Officer PO Box 100, Albany, OR 97321. Oral or written notification of the revocation of authorization for drug and alcohol information shall be accepted. Any request for revocation must be provided to the alcohol and drug program.
- I understand I may refuse to sign this form. I know that the Department may not make my signing of an authorization form a condition of my treatment.
- I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and no longer protected under federal or state law, EXCEPT THAT disclosure by the recipient of information related to mental health and alcohol or drug treatment is prohibited without my authorization unless otherwise permitted by federal or state law.
- I understand that alcohol and drug treatment records are protected under federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR part 2) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 CFR Parts 160 & 164), and cannot be disclosed by this Program or re-disclosed by those receiving this information without my written consent, or as otherwise permitted by these regulations.
- I understand that my information is confidential and may be protected by state and federal laws, and I approve the release of my information in accordance with this authorization.
- I am signing this authorization voluntarily and without pressure or coercion.
- I acknowledge that I have been offered a copy of this form.

SIGNATURE (Full legal signature of individual or authorized personal representative)	Relationship to Individual:

Print Name of Person Signing This Authorization	Date:
Signature of Parent or Personal Representative if required	Date:

For Department Use Only	
Received by:	Date Received:
ID verified by Staff:	Records: ☐ Mailed ☐ Picked up ☐ Emailed ☐ Other: