Adult Team
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Clackamas Behavioral Health Division
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Children's Team
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BH-MHOKidsCare@co.clackamas.or.us

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Client Name _____ **DOB** _____ **Case #** _____

Section A. I hereby authorize and give my permission to the providers / individuals listed below to release and/or receive a copy of my record:

Please Check All Boxes That Apply:

☐ Send records **FROM CBHD** to: Name: _____

☐ Give records **TO CBHD** from: Address: _____

☐ **VERBAL** exchange with CBHD &: City/State/Zip: _____ _____ _____

Phone: _____ Fax: _____

Deliver by: ☐ Fax ☐ Mail ☐ Pick-up on _____ ☐ Email _____

Section B. Purpose for this disclosure (check all that apply):

☐ Coordination of Care ☐ Discharge Planning ☐ Eligibility Determination*

☐ Legal* ☐ At the request of the client*

☐ Other* (specify) _____

* Reasonable fees may be charged to cover the cost of preparing, copying and mailing your records.

Section C. I specifically give permission to release the following records:

☐ Assessments / Evaluations	☐ Progress Notes	☐ Psychiatric / Psychological Testing	☐ Admission / Discharge Summary
☐ Treatment / Service Plans	☐ Medication Records	☐ Academic Records / Progress	☐ Financial / Billing Records
☐ Current Mental Status	☐ Laboratory Reports	☐ Vocational Records	☐ ENTIRE RECORD
☐ Abstract	☐ Other (specify) _____		

Release my records from the following dates: From Treatment Date: _____ to Treatment Date: _____

Section D. RELEASE OF THE FOLLOWING RECORDS AND INFORMATION REQUIRES SPECIFIC AUTHORIZATION: **By initialing** the spaces below, I specifically authorize the voluntary release of the following medical records, if such records exist. I understand federal and state law protects them.

_____ Mental Health _____ Alcohol / Drug _____ Genetic Testing _____ HIV / AIDS

Section E. I understand I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. A revocation will not affect inspection of records necessary to validate expenditures by or on behalf of government entities. To revoke this authorization, please send a written statement to CLACKAMAS BEHAVIORAL HEALTH DIVISION and state that you are revoking this authorization. Unless revoked earlier, by CHECKING one box below this consent will expire:

☐ **1 year** from the date I sign **OR** ☐ upon the **event** or **date** indicated: _____

SIGNATURE (Client, Guardian, or Person Authorized To Sign for Client)*	**NAME-Please Print**	**RELATIONSHIP TO CLIENT**	**DATE**

SIGNATURE (Parent of minor A&D client *or* Witness if client makes mark)	**NAME-Please Print**	**RELATIONSHIP TO CLIENT or TITLE**	**DATE**

*If Other than Parent, **PROOF OF LEGAL REPRESENTATION MUST BE PROVIDED** in the form of custody order, guardianship order, or medical power of attorney.

SIGNIFICANT INFORMATION: Information used or disclosed under this authorization may be subject to re-disclosure by others without your permission and no longer protected under federal law. In some instances, federal and state law may protect your information from being shared if it is HIV/AIDS information, mental health information, genetic testing 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.

If your written permission to release health information about you is needed to determine your eligibility for the Oregon Health Plan or other medical program, and you do not give us permission to release your health information, then you may not be able to show that you are eligible.

TO THE RECIPIENTS OF PROTECTED HEALTH INFORMATION: The information disclosed to you by this authorization is protected by state law (ORS 179.505, 192.518) and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol and drug treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.