Authorization for Disclosure, Sharing and Use of Individual Information

This form allows the referral, coordination and oversight of provider services.

Legal last name:	**First name:**	MI:	Date of birth:
Other names:			
Address:	City:	State:	ZIP:
Phone number:	Email address:		
ID type and number:			

Legal last name of representative (if any):	**First name:**	MI:
Relationship to the person listed above:		
Address:	City:	State: ZIP:
Phone:	Email address:	

When I sign this form, I authorize those I name to give specific personal information about me. If I answer "yes" to "mutual exchange," I allow agencies I name to share information back and forth. This is so they can provide better services to me.

Release FROM:

Purpose of the disclosure, sharing and use:

Entity name: Choose one (use the arrow on the right to expand the dropdown list) or type in

Specific information to be disclosed:

Date of records:	Contact person:

Address:	City:	State:	ZIP:

Phone number:	Email address:
Fax number:	Is this a mutual exchange? ☐ Yes ☐ No

Expiration date or event[1]:

Do you request specially protected health information to be released? ☐ Yes ☐ No

Specially protected information: There may be additional laws for use and disclosure if there is the type of record or information listed in this box. I understand that **no information** will be disclosed **unless** I or my representative **initial next to the information types below**[2].

HIV/AIDS: _____ **Mental health:** _____ **Genetic testing:** _____

Alcohol or drug diagnoses, treatment, referral: _____

If there is any specific information you do **not** want to share, what is it?

Release TO:

Purpose of the disclosure, sharing and use:

Entity name: Choose one (use the arrow on the right to expand the dropdown list) or type in

Specific information to be disclosed:

Date of records:	Contact person:		
Address:	City:	State:	ZIP:

Phone number:	Email address:
Fax number:	Is this a mutual exchange? ☐ Yes ☐ No

Expiration date or event[1]:

Do you request specially protected health information to be released? ☐ Yes ☐ No

Specially protected information: There may be additional laws for use and disclosure if there is the type of record or information listed in this box. I understand that **no information** will be disclosed **unless** I or my representative **initial next to the information types below**[2].

HIV/AIDS: _____ **Mental health:** _____ **Genetic testing:** _____

Alcohol or drug diagnoses, treatment, referral: _____

If there is any specific information you do **not** want to share, what is it?

Your acknowledgments

- I was given the chance to ask questions about this form and what it does.
- I understand what this form means and I approve of the disclosures or releases listed.
- I understand that state and federal law protect information about services I receive from any listed:
  - Agency
  - Business
  - Organization
  - Person
- This authorization is valid for one year from the date I sign it unless otherwise noted.
- I understand my representative or I can cancel this authorization. However, information shared before I cancel cannot be undone. I can orally cancel an authorization for drug and alcohol information. All other cancellation requests must be written. I must provide any request to cancel to the agency, business, organization or person that is providing the information.
- I understand that federal or state law prohibits re-disclosure of the following, without authorization by me or my representative:
  - Drug and alcohol diagnosis
  - HIV and AIDS information
  - Mental health
  - Referral information
  - Treatment records
  - Vocational rehabilitation records
- I understand that information that does not have re-disclosure restrictions may be re-disclosed. Re-disclosed information may no longer be protected under federal or state law.

Your acknowledgments, continued

- I understand someone may need to contact me about this form to confirm my identity. They may also need to get more information.
- I understand that deciding not to sign this form may:
  - Prevent agencies from deciding if I am eligible for certain programs.
  - Prevent me from getting referrals. It may also make coordination of provider services more difficult.
  - Affect my ability to get health services if it is necessary to share information.
  - Keep the Oregon Health Plan (OHP) or Medicaid from paying for a service because they do not have authorization.
- **I am signing this authorization of my own free will.**

Signature:	☐ I am the authorized representative[3]
Printed name:	Date:

Security statement

This form may contain your personal information. If you return the form by email there is some risk it could go to someone you don't want to have the information. If you are not sure how to send a secure email, consider using regular mail or fax.

Endnotes

1. This authorization is valid for one year from the date I sign it, unless otherwise noted.
2. If you are requesting to release specially protected information from the Oregon Department of Corrections, please see page 2 of the instructions pages for additional disclosures.
3. If the person legally authorized to act for the person on this form signs, they must give evidence of their authority to do so.

Instructions by section

When you submit the form, you do not need to include the instruction pages.

Creating preset templates
To save time, you can preset the number and type of sections. You can also prefill your organization's information, then save template versions of this form for quick printing. Use the non-printing "Template" field in the top right corner of form page 1 and name the template for your future reference.

Release TO and FROM sections	
Purpose of disclosure, sharing and use	• Give specific reasons why the information disclosure, sharing and use are needed. • If the person does not want to provide a reason in this field the requesting entity may include the statement "at the request of the person" as the purpose the person initiates the authorization.
Entity name	• Type in the entity's name. An entity's name must be specific. For example, listing "medical" or "service provider" is not adequate. Please list the name of the medical or service provider. For a person or other type of organization, such as a school or employer, list the name of the person or other type of organization. • Here are some of the most commonly requested Oregon agencies (this is not a complete list): ▸ ODHS Aging and People with Disabilities (APD) ▸ ODHS Child Welfare (CW) ▸ ODHS Office of Developmental Disabilities Services (ODDS) ▸ ODHS Self-Sufficiency Program (SSP) ▸ ODHS Vocational Rehabilitation (VR) ▸ Oregon Commission for the Blind ▸ Oregon Department of Corrections ▸ Oregon Department of Education ▸ Oregon Department of Justice ▸ Oregon Employment Department ▸ Oregon Health Authority (OHA) ▸ Oregon Housing and Community Services ▸ Oregon State Hospital ▸ Oregon State Police ▸ Oregon Youth Authority • Other agencies, businesses, organizations and persons can also be listed, including the person whose information is being requested (self).
Specific information to be disclosed	• Type in a description of the specific information to be disclosed. Some examples of specific information are: ▸ Assessments ▸ Case plans ▸ Financial information ▸ Medicaid billing summaries ▸ Psychological reports ▸ Results of urinalysis ▸ Treatment plans • Do not indicate "entire record" unless it is necessary to accomplish the purpose (see "Purpose of the disclosure, sharing and use", above).
Date of records	• Indicate the specific date range for the requested records
Expiration date or event	• This authorization is valid for one year from the date I sign. unless otherwise noted. For example, if "hospital discharge" or "end of litigation," is noted
Mutual exchange	• A "Yes" allows the specific information listed on the form to go back and forth between the record holder and the people or programs listed on this authorization. Mutual exchange opens all requested records for discussion between the record requestor and specified record holders.

Release TO and FROM sections, continued	
Did you request special health information to be released?	• Choosing "Yes" will display a section where special health information types can be stated. • A check mark in the space next to the type of health information is not enough. • The person must initial the space next to the information if they agree to release this information. *****Special health information and the Oregon Department of Corrections:** • **If you are releasing "Alcohol and drug information"** from the Oregon Department of Corrections, the form **must** be initialed in the "Are you requesting special health information to be released?" section, to be included in other documents. Records will not be released without your initials indicating that you have granted this specific release. ▸ **PROHIBITED RE-DISCLOSURE:** This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. • **If you are releasing, "HIV/AIDS related records," "Genetic testing information," and/or "Mental health information,"** from the Oregon Department of Corrections, the form **must** be initialed in the "Are you requesting special health information to be released?" section, to be included in other documents. Records will not be released without your initials indicating that you have granted this specific release. Copies will not be released to inmates while incarcerated.
Is there any specific information **not** to release?	• If any specific information should not be included when the records are released, please list them here.
Re-disclosure	• Re-disclosure is the disclosure of information by the person on this form. • There may be restrictions on the re-disclosure of information released under this form. • Federal and state regulations prohibit re-disclosure of alcohol and drug, and HIV or AIDS information without specific authorization.

Client acknowledgment section	
Signature of the person on this form or a person legally authorized to act for them.	• A person legally authorized to act for the person on this form should never be asked to sign a blank or incomplete authorization form.

Releasing entity: Document when records were shared.

- Entity must:
  - ▸ Maintain a copy of the completed authorization form, either electronically or in paper file, and
  - ▸ Follow agency retention schedules.
- If completed authorization forms are stored electronically, a process shall be in place for cancellation. If an authorized requester later opts out, that revocation must be noted electronically.
- Do not use labels on the authorization form.
- When completed correctly, the form is the only thing needed to process a disclosure.

Agency contact information

For questions or help completing this form, please contact the agency you work with.

- Oregon Health Authority: 503-947-2340
- Oregon Department of Human Services: 503-945-5600
- Oregon Commission for the Blind: 971-673-1588
- Oregon Employment Department: 800-237-3710
- Oregon Department of Education: 503-947-5600
- Oregon Housing and Community Services: 503-986-2000
- Oregon Department of Justice: 503-378-4400
- Oregon Department of Corrections: 503-945-9090
- Oregon Youth Authority: 503-373-7205
- Oregon State Police: 503-378-3720