

Mid-Columbia Center for Living- Developmental Disabilities Program

<input type="checkbox"/> Hood River 1610 Woods Court Hood River, OR 97031 Phone: (541) 386-2620 Fax: (541) 386-6075	<input type="checkbox"/> The Dalles 419 East Seventh Street, Rm. 207 The Dalles, OR 97058 Phone: (541) 296-5452 Fax: (541) 296-9418
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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, _____ authorize Mid-Columbia Center for Living (MCCFL) to:
Print Name

Release Information to:
 Obtain Information from:
 Exchange Information with:

VIA:
 Fax
 Mail
 Verbal

NAME	ADDRESS	PHONE/FAX#

HEALTH INFORMATION: The health information that is subject to this Authorization pertains to:

myself DOB _____ ,
 my child _____ DOB _____ ,
 Other (_____)

Print Name

and includes the following:

- Cognitive/ Psychological/ IQ evaluations
 - Psychosocial summaries
 - Adaptive behavior assessments
 - Speech, occupational, and physical therapy assessments and recommendations
 - Individual Support Plans, Family Support Plans, school records including IEP and IFSP
 - Genetic Information** I recognize that the information released may contain genetic information that is protected by state law.(ORS659.710) I specifically consent to its release.
- Please date and sign: _____**

To be used for:

- Case management services
- To assist in planning for services
- Eligibility for services as a person with a developmental disability
- The sole purpose of:

I also consent for the release of *appointment related information only (via e-mail, fax, or verbal) to the above listed agency/agencies (e.g., school, juvenile department).*

TERM: This Authorization will remain in effect:

From the date of this Authorization until: _____, 200__ but not to exceed one year from today's date.

Until the following event occurs _____

Other: _____

I understand that once **MCCFL** discloses my health information to any of the individuals/agencies specified above in accordance with the terms and conditions of this Authorization, **MCCFL** cannot guarantee that these individuals/agencies will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may at any time make a written request to **MCCFL** to inspect and/or obtain a copy of my health information, and that **MCCFL** will within FIVE (5) working days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the quality of **MCCFL's** treatment of me, enrollment in the health plan, or eligibility for benefits.

I understand that this Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to **MCCFL's** Privacy Officer. The revocation will be effective immediately upon **MCCFL's** receipt of my written notice, except that the revocation will not have any effect on any action taken by **MCCFL** in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize **MCCFL** to use or disclose health information in the manner described above.

Signature of Individual

Date

Signature of Witness

If individual is 13 years or younger or is otherwise unable to sign this Authorization, please complete the information below:

Signature

Date

Witness

Relationship to Client: Parent
 Health care power of attorney

Guardian Authorized health care representative
 Other Authorized Personal Representative

Provided a copy of signed Authorization to individual