Mid-Columbia Center for Living

☐ **Hood River**	☐ **The Dalles**
1610 Woods Court	419 East Seventh Street, Rm. 207
Hood River, Oregon 97031	The Dalles, Oregon 97058
Phone: (541) 386-2620	Phone: (541) 296-5452
Fax: (541) 386-6075	Fax: (541) 296-9418

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

CLIENT NAME:	**DATE OF BIRTH:**

For the above-named client, Mid-Columbia Center for Living (MCCFL) is authorized to:

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

NAME/ AGENCY	ADDRESS	PHONE/FAX#

THE HEALTH INFORMATION THAT IS SUBJECT TO THIS AUTHORIZATION PERTAINS TO:

☐ Myself ☐ My child_________________________ ☐ Other ___________________________

Print Name — Specify relationship; see bottom of next page

AND INCLUDES THE FOLLOWING:

___Mental health treatment including:
- ___Assessments
- ___Progress notes
- ___Other clinical records:________________

___Substance abuse treatment including:
- ___Assessments
- ___Progress notes
- ___Other clinical records:________________

___Case management services
___Information requested for legal purposes (e.g., court-mandated)
___Eligibility for services as a person with a developmental disability
___Appointment dates & times
___Referral information
___Medical Records
___HIV-related information: *I understand that this information may not be disclosed or re-disclosed without the specific written authorization of the individual to whom it pertains. [OAR §333-012-0270(9)(a)]*
___Other: ____

FOR THE PURPOSE OF:

___Verification of insurance eligibility
___Coordinating or planning for treatment, care, or services
___Implementing case management services
___Medication management
___Determining eligibility for services as a person with a developmental disability
___Sharing *contact, demographic, appointment related information only* (**via e-mail**, fax, or verbal) to the above-listed agency and/or the MCCFL Program Evaluation Team
___Other: ____________

TERM:

This authorization will remain in effect for one year from the date signed.
__Alternatively, I elect to have this authorization in effect until __________, 20__ OR until the following event occurs or condition exists: ____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as stated above. The revocation may be verbal if I am a client in the Alcohol and Drug Treatment Program, and must be in writing if I am enrolled in a Mental Health Services Program.

I understand that any information regarding participation in an Alcohol and Drug treatment program at MCCFL is protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally prosecute any alcohol or drug abuse patient.

I understand that all of my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, though MCCFL cannot guarantee that this individual/agency will not re-disclose my health information to a third party. The third party may not be required to abide by applicable federal and state law governing the use and disclosure of my health information; thus, my health information may no longer be protected by HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure.

I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

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 Authorizing Individual Date Signature of Witness

A copy of signed Authorization has been offered to the individual: _________Accepted _________Declined

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

The following individuals must provide documentation proving authorized representation:

☐ Guardian ☐ Authorized health care representative ☐ Health care power of attorney

☐ Other Authorized Personal Representative (for Mental Health Clients) Version 05.14.2012