Behavioral Health Release of Information

Authorization for Use or Disclosure of Protected Health Information

Polk County Behavioral Health Locations:

182 SW Academy Street, STE 333
Dallas, OR 97338
Phone: (503) 623-9289 Fax: (503) 831-1726

1520 Plaza Street NW
Salem, OR 97304
Phone: (503) 585-3012 Fax: (503) 585-0128

1310 Main Street East
Monmouth, OR 97361
Phone: (503) 400-3550 Fax: (503) 837-0095

Please complete this entire form. Incomplete authorizations are not valid and will be returned for completion.

Client Information

Client's Full Name: _____

Date of Birth: _____

Primary Phone #: _____

I hereby authorize Polk County Behavioral Health to:

❑ DISCLOSE INFORMATION TO ❑ OBTAIN INFORMATION FROM

Name: _____

Primary Phone #: _____ Fax #: _____

Address: _____

City, State, ZIP _____

❑ Primary Care Physician
❑ ADES
❑ DHS or their Attorney
❑ Parole/Probation Officer
❑ Foster Parent
❑ School
❑ Emergency Contact
_____

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 unless further disclosure is expressly permitted by the 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Purpose of the Disclosure of Information

❑ Treatment planning and care
❑ Diagnostic clarity
❑ Reporting requirements to ADES, DHS, Parole/Probation
❑ Scheduling of appointments
❑ Emergency purposes
❑ Insurance
❑ Workers' Comp.
❑ School
❑ Legal proceedings
❑ Personal use
☐ Other

Protected Sensitive Information

By placing my **INITIALS**, I specifically authorize the release of the following sensitive information:

_____ Mental Health Information

_____ Drug/Alcohol Diagnosis, Treatment, or Referral Information

_____ HIV/AIDS Information

_____ Genetic Testing Information

Expiration: This permission is valid for the duration of my episode of care *or* until the date or event specified:

- I may revoke this authorization in writing by presenting my written request at any of the Polk County Behavioral Health locations. A verbal revocation will be permitted for authorizations related to Substance Use Disorder treatment. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment.
- I may inspect or copy any information used and/or disclosed under this authorization.
- Information used or disclosed by this authorization may be subject to re-disclosure and may no longer be protected under federal or state laws EXCEPT for sensitive information including Mental Health Information, Alcohol/Drug diagnosis, treatment or referral information, HIV/AIDS information, or genetic testing information.

I have read this authorization, and I understand it.

_____ _____

Signature of Client/Parent/Legal Guardian Date Signature of Witness Date

Relationship to Client: ❑ Self ❑ Parent -OR- ❑ Legal Guardian (proof of guardianship required)

_____

Print the name of the person signing

FOR OFFICE USE ONLY

I hereby revoke this authorization effective: _____ _____

Client/Parent/Legal Guardian Signature (required for Mental Health Information)

❑ Verbal revocation (permitted for Substance Use Disorder treatment information)

Using This Form

1. **Assistance:** Whenever possible, a PCBH staff person should assist you in filling out this form. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.

2. **Guardianship/Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.

3. **Cancel:** If you later want to cancel this authorization, contact your PCBH staff person. You may be asked to put the cancellation request in writing. Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is canceled. PCBH may continue to use information obtained prior to cancellation.

4. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.

5. **Special Attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed.

6. **Re-disclosure:** Federal regulations (42 CFR Part 2) prohibit making any further disclosure of Alcohol and Drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.

7. **Privacy Practices:** All clients who enroll in services will be provided a copy of Polk County Behavioral Health Privacy Practices, which outlines how we may share protected health information, client rights, and how to file a complaint or report a suspected problem.