Behavioral Health
Authorization For Use & Disclosure of Information

By signing this form I am allowing my protected health information to be disclosed and used, written or orally.

Client Name (print clearly):_____ **DOB:**_____

SECTION A

I hereby authorize

☐ Polk County Behavioral Health to **provide** records or information **TO:**

☐ Polk County Behavioral Health to **request** records or information **FROM:**

Name:_____

Address:_____

City/State/Zip:_____

Phone:_____ Fax:_____

☐ Primary Care Physician
☐ ADES
☐ DHS
☐ Emergency Contact
☐ Parole/Probation Officer
☐ Foster Parent
☐ School
☐ Other:_____

Records TO Polk County Behavioral Health should be sent to:

☐ 182 SW Academy Street Suite 333
Dallas, OR 97338
Tel: 503-623-9289 Fax: 503-831-1726

☐ 1520 Plaza Street NW
Salem, OR 97304
Tel: 503-585-3012 Fax: 503-585-0128

SECTION B

Initial Here	Specific Information to be Disclosed *(Initial if OK to release)*	Purpose for Authorization
	Records of mental health / psychiatric assessment & treatment.	☐ Treatment planning/ delivery ☐ Diagnostic clarity ☐ Reporting Requirements to ADES, DHS, Probation, Other ☐ For emergency purposes only ☐ At the request of the client *(reasonable fees may be charged to cover the cost of preparing, copying and mailing your records)* ☐Other:_____
	Alcohol/Drug - diagnosis, treatment, UA's, referrals	
	HIV/AIDS related records	
	Medical treatment & lab records	
	Emergency Contact	
	Other:	

SECTION C

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

I may revoke this authorization in writing by presenting my written revocation to the clinic or site where I received services. 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, payment, or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization. Members of Willamette Valley Community Health CCO (WVCH CCO) may not revoke sharing of information between other WVCH CCO network providers.

I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, Sexually Transmitted Diseases, mental health, and drug/alcohol abuse diagnosis, treatment, or referral information, federal or state law may prevent the recipient from re-disclosing this information. I have read this authorization, and I understand it.

_____ _____
Signature of Client or Legal Personal Representative Date

_____ _____
Signature of Witness Date

_____
Relationship to Client

For Office Use Only

*I hereby revoke this authorization effective:*_____

☐ *Verbal Revocation permitted for A&D information*

_____
Signature required for Mental Health 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 cancelled. 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. **Willamette Valley Community Health Coordinated Care Organization Members (WVCH CCO):** Limited information may be shared within the WVCH CCO provider network for the purpose of providing whole-person care. Protected health information may be disclosed by health care providers participating in WVCH CCO without member authorization:
    a. To other health care providers participating in the CCO for treatment purposes,
    b. To the CCO for health care operations and payment purposes, permitted by ORS 192.558; and
    c. To public health entities as required for health oversight purposes.
    d. Mandated disclosures under state law do not override the federal protections for drug and alcohol records found in 42CFR Part 2.