DHS Oregon Department of Human Services

Authorization for Use and Disclosure of Information

Oregon Health Authority

This form is available in alternative formats including Braille, large print, computer disk and oral presentation.

Legal last name of client/applicant:	First:	MI:	Date of birth:
Other names used by client/applicant:			Case ID number:

By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:

Section A

Release from one record holder: *(individual, school, employer, agency, medical or other provider)*	**Specific information to be disclosed:**	**Mutual exchange: Yes/No**

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

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

Alcohol/drug diagnoses, treatment, referral: _____

Section B

Release to: ***(address required if mailed)*** **If releasing to a team, list members.**	**Purpose:**	**Expiration date or event*:**
Falls City Service Integration Team-City of Falls City, Dallas Police Department, Faces Forward In-Faith, Falls City Arts Council, Falls City School District, Mid-Willamette Valley Community Action Agency (Polk Resource Center, Head Start), Oregon Public Health Institute, Oregon Child Development Coalition, OSU (Extension Services), Polk County Board of Commissioners, Polk County Family & Community Outreach (SI, MVP, SBMH, Prevention, and Cover Oregon), Polk County Health Services (Behavioral Health, Public Health), Polk County Juvenile Department, Polk County Sheriff, SABLE House, Salem Free Clinics, Salem Health, State of Oregon Department of Human Services (Self-Sufficiency, Child Welfare, Seniors & People with Disabilities), The Church of Jesus Christ of Latter Day Saints, The Salvation Army, Willamette Educational Service Department, United Way of Mid-Willamette Valley and Victim Offender Reconciliation Program (VORP), West Valley Hospital		

***This authorization is valid for one year from the date of signing unless otherwise specified.**

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, mental health and drug/alcohol diagnosis, treatment, vocational rehabilitation records or referral information without specific authorization.

Section C

Full legal signature of individual or authorized personal representative:	**Relationship to client:**	**Date:**

Name of staff person *(print)*:	**Initiating agency name/location:**	**Date:**

Full legal signature of agency staff person making copies:	**This is a true copy of the original authorization document.**
Print staff person name:	

See "Required Information" on page 2 of this form.
(not valid without page 2)

Required information for the client

To provide or pay for health services: If the Department of Human Services (DHS) or Oregon Health Authority (OHA) is acting as a **provider** of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. *(Examples of this would be assessments, tests or evaluations.)* Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may also be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS or OHA program or service not acting as a health care provider

This is a voluntary form. DHS or OHA cannot condition the provision of treatment, payment or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Using this form

1. **Terms used: Mutual exchange:** A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, a DHS or OHA staff person should fill out this form with you. **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.
3. **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.
4. **Cancel:** If you later want to cancel this authorization, contact your DHS or OHA staff person. You can remove a team member from the form. You will be asked to put the cancellation request in writing.
   Exception: 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. DHS or OHA can continue to use information obtained prior to cancellation.
5. **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.
6. **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 and the purpose.

Redisclosure: 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.

Note: Oregon's health services and programs have been transferred from the Department of Human Services (DHS) to the Oregon Health Authority (OHA). DHS will continue to determine eligibility for many of the health programs, as well other programs administered by DHS.