Authorization for Disclosure, Sharing and Use of Individual Information

The purpose of this form includes referring, coordinating and monitoring your services with providers, as described below.

Legal last name of individual:	**First name:**	**MI:**	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification type: Choose one			
Legal last name of representative (*if any*):	**First name:**		**MI:**
Relationship to individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		

By signing this form, I authorize the named record holder(s) to disclose the following specific confidential information about me. Whenever "mutual exchange" is checked, those named agencies will be able to share information back and forth to better provide services to me.

REQUESTING AGENCY, BUSINESS, ORGANIZATION OR INDIVIDUAL	
Purpose of the requested disclosure, sharing and use: Resource referral, client advocacy, eligibility determination and payment information for financial assistance	
Entity name: Polk County Service Integration and affiliated partners	
Specific information to be disclosed: Client contact information and address, household and demographic information, verification of need and sustainability plan, resources accessed, referrals given, program enrollment and benefits amounts, other information relevant to - or in support of - the Service Integration funding request (landlord form, applicable bills or quotes, etc)	
Date of records: Most recent	
Contact person: Service Integration Program Coordinator	Address: 182 SW Academy Street, Suite 220
City, state and ZIP: Dallas, OR 97338	
Phone number: 503-623-9664 ext 2457	Email address: fco.service.integration@co.polk.or.us
Expiration date or event†:	Mutual exchange: ◉Yes ○No
Are you requesting special health information to be released? ○Yes ◉No	
Is there any specific information **not** to release? ○Yes ○No I do not want to share the following documents:	

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RELEASING AGENCY(IES), BUSINESS(ES), ORGANIZATION(S) OR INDIVIDUAL(S)	
Purpose of the requested disclosure, sharing and use: Resource referral, client advocacy, eligibility determination and payment information for financial assistance	
Entity name:	
Specific information to be disclosed: Client contact information and address, household and demographic information, verification of need and sustainability plan, resources accessed, referrals given, program enrollment and benefits amounts, other information relevant to - or in support of - the Service Integration funding request (landlord form, applicable bills or quotes, etc)	
Date of records: Most recent	
Contact person:	Address:
City, state and ZIP	
Phone number:	Email address:
Expiration date or event†:	Mutual exchange: ◉Yes ○No
Is there any specific information **not** to release? ○Yes ○No I do not want to share the following documents:	

CLIENT ACKNOWLEDGMENT	
• I was given the chance to ask questions about this form and what it does. • I understand what this form means and I approve of the disclosures or releases listed. • I understand that state and federal law protect information about services I receive from the listed agency(ies), business(es), organization(s) and individual(s). • This authorization is valid for one year from the date of signing unless otherwise specified.† • I understand that I can revoke (*cancel*) this authorization at any time and revocation (*cancellation*) will not apply to any information already disclosed or released. Except for drug and alcohol information, either I or a person legally authorized to act on my behalf must submit the cancellation request in writing. Oral or written notification of the cancellation of authorization for drug and alcohol information shall be accepted. Any request for cancellation must be provided to the requesting agency, business, organization or individual. • I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information or vocational rehabilitation records without authorization by me or a person legally authorized to act on my behalf. • I understand that information that is not subject to restrictions on re-disclosure as noted immediately above may be subject to re-disclosure and the information that is re-disclosed may no longer be protected under federal or state law. • I understand someone may need to contact me about this form to confirm my identity or to collect additional information. • **I am signing this authorization of my own free will.**	
Signature of individual or a person legally authorized to act on behalf of the individual:	
Printed name:	Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual must be provided.	

FOR **RELEASING** AGENCY, BUSINESS, ORGANIZATION OR INDIVIDUAL USE ONLY		
Name and location of releasing individual, agency, business or organization:		
Name of staff person (*print*)	Signature of staff person	Date:

Required information for the individual — Please read

Deciding not to sign this form may:

- *Prevent agencies from deciding if you are eligible for certain programs.*
- *Prevent you from getting referrals and make coordinating services with providers more difficult.*
- *Affect your ability to get services if this form's purpose is to share information necessary to your health services.*
- *Keep the Oregon Health Plan or Medicaid from paying for a service because they do not have authorization.*

Security statement

This form may contain your personal information. If you return the form by email there is some risk it could be intercepted by someone you did not send it to. If you are not sure how to send a secure email, consider using regular mail or fax.

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

‡ *For questions or help completing this form, please contact the agency(ies) with which you are working:*

- *Oregon Health Authority: 503-947-2340*
- *Oregon Department of Human Services: 503-945-5600*
- *Oregon Department of Employment: 800-237-3710*
- *Oregon Department of Education: 503-947-5600*
- *Oregon Housing and Community Services: 503-986-2000*
- *Oregon Department of Justice: 503-378-4400*
- *Oregon Department of Corrections: 503-945-9090*
- *Oregon Youth Authority: 503-373-7205*
- *Oregon State Police: 503-378-3720*

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