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:	
Entity name: Choose one	
Date of records: Choose one	
Contact person:	Address:
City, state and ZIP:	
Phone number:	Email address:
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	

RELEASING AGENCY(IES), BUSINESS(ES), ORGANIZATION(S) OR INDIVIDUAL(S)	
Purpose of the requested disclosure, sharing and use:	
Entity name: Choose one	
Date of records: Choose one	
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	

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*

Instructions by section

When submitting the form, it is not necessary to include these instruction pages.

Creating pre-set templates
To save time, you can pre-set the number and type of sections and prefill your organization's information, then save template versions of this form for quick printing. Use the non-printing "Template" field in the top right corner of the form to name the template for your future reference.

REQUESTING and **RELEASING** AGENCY, BUSINESS, ORGANIZATION OR INDIVIDUAL sections	
Purpose of the requested disclosure, sharing and use	• Give specific reasons why the information disclosure, sharing and use are needed. • The requesting entity may include the statement "at the request of the individual" as the purpose when an individual initiates the authorization and does not choose to provide a reason in this field.
Entity name (*drop-down list*)	• Choose an entity from the drop-down list. • If the entity is not listed, choose "Other (please type in here):" and type in the entity's name. An entity's name must be specific. For example, listing "medical" or "service provider" is not adequate. Please list the name of the medical or service provider. For an individual or other type of organization, such as a school or employer, list the name of the individual or other type of organization.
Specific information to be disclosed (*pops up after an entity is selected*)	• Choose a document type from the drop-down list. • If an information type is not listed, choose "Other (please type in here):" and type in the information type. Some examples of specific information are assessments, treatment plans, results of urinalysis, psychological reports, financial information, case plans and Medicaid billing summaries. • Do not indicate "entire record" unless it is necessary to accomplish the purpose (*see "Purpose of the requested disclosure, sharing and use", above*). • Use the buttons to add or delete additional requested information types, if needed.
Date of records	• Indicate the specific date range for the requested records.
Expiration date or event	• This authorization is valid for one year from the date of signing unless a specific expiration date or expiration event, such as "hospital discharge" or "end of litigation," is specified.
Mutual exchange	• A "Yes" allows the specific information listed on the form to go back and forth between the record holder and the people or programs listed on this authorization. Mutual exchange opens all requested records for discussion between the record requestor and the specified record holders.
Are you requesting special health information to be released?	• Choosing "Yes" will display a section where special health information types can be specified. • A check mark in the space next to the type of health information is not sufficient; initials must be placed in the space next to the information if the individual agrees to release this information. • If you need this section visible in a printed copy, please make sure to choose "Yes" prior to printing.
Is there any specific information **not** to release?	• Choosing "Yes" will display a text box where specific information can be listed. • If any specific information should ***not*** be included when the records are released, please list them here. • If you need this section visible in a printed copy, please make sure to choose "Yes" prior to printing.

Re-disclosure	• Re-disclosure is the disclosure of information by the recipient. • There may be restrictions on the re-disclosure of information released under this form. • Federal and state regulations prohibit re-disclosure of alcohol and drug, and HIV/ AIDS information without specific authorization.
Adding additional requesting and releasing entities	• If multiple requesting or releasing entities are needed, use the ADD or REMOVE buttons to add or remove additional "Releasing agency(ies), business(es), organization(s) or individual(s)" sections before you print the form.

CLIENT ACKNOWLEDGMENT section	
Signature of individual or a person legally authorized to act on behalf of the individual	• An individual or person legally authorized to act on behalf of the individual should never be asked to sign a blank or incomplete authorization form.

FOR RELEASING AGENCY, BUSINESS, ORGANIZATION OR INDIVIDUAL USE ONLY section
• Entity shall maintain a copy of the completed authorization form, either electronically or in paper file, following agency retention schedules. • If completed authorization forms are stored electronically, a process shall be in place for revocation (*cancellation*). If a signed authorization is later revoked (*cancelled*), that revocation must be noted electronically. • Do not use labels on the authorization form. • When completed properly, the form can stand alone to process a requested disclosure.