# Information Memorandum Transmittal
# Aging and People with Disabilities

DHS Oregon Department of Human Services

Mat Rapoza
***Authorized signature***

**Number: APD-IM-19-104**
**Issue date:** 12/16/2019

**Topic:** Long Term Care

**Due date:**

**Subject:** Statewide Release of Information (form 3010) available in Oregon Access

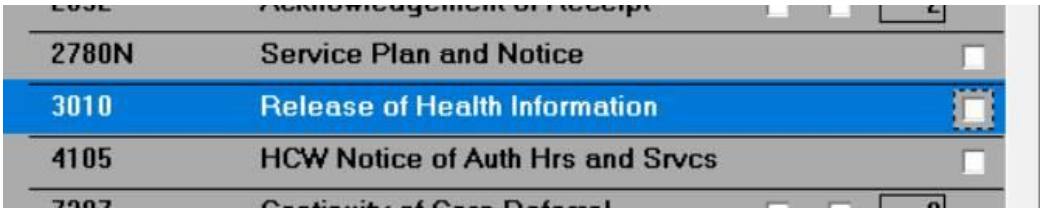
**Applies to (*check all that apply*):**

- ☐ All DHS employees
- ☒ Area Agencies on Aging: Types A and B
- ☒ Aging and People with Disabilities
- ☐ Self Sufficiency Programs
- ☐ County DD program managers
- ☐ Support Service Brokerage Directors
- ☐ ODDS Children's Residential Services
- ☐ Child Welfare Programs
- ☐ County Mental Health Directors
- ☐ Health Services
- ☐ Office of Developmental Disabilities Services (ODDS)
- ☐ ODDS Children's Intensive In Home Services
- ☐ Stabilization and Crisis Unit (SACU)
- ☐ Other (*please specify*):

**Message:**

The State Form 3010, Authorization for Disclosure, Sharing and Use of Personal Information (commonly referred to as the Release of Information) was made available for use as of April 1, 2019.

The 3010 replaces form 2099 and is now available on Oregon Access. The title of the form in Oregon Access remains: "Release of Health Information".

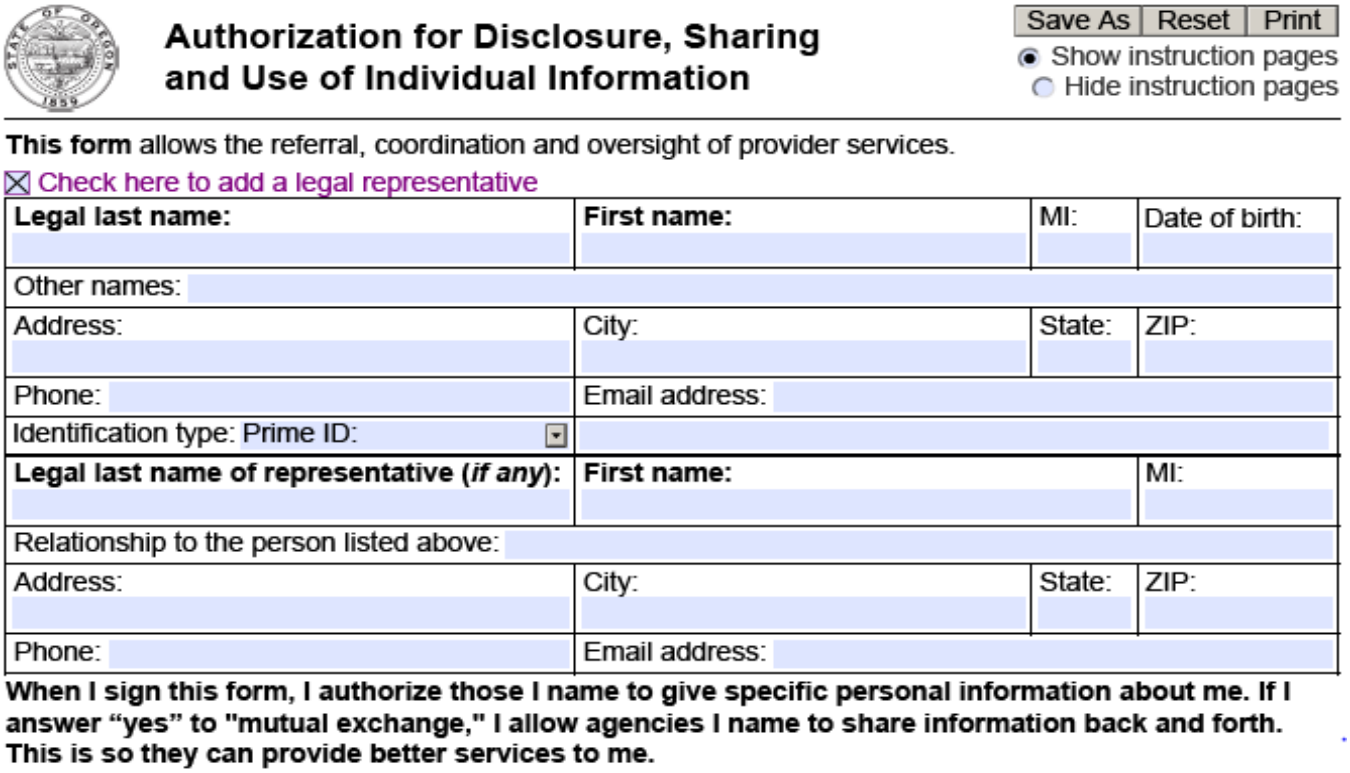



The 3010 is also available in English, Chinese (Simplified and Traditional), Spanish, Russian and Vietnamese language translations on the forms server.

The 3010 is the only accepted Release of Information for Medicaid, Oregon Project Independence and the Older American Act Programs.

**Tips for completing the 3010:**

Instructions for completing the 3010 can be found on page 3 of the form by clicking "Show instruction pages" at the top right of the form. If a legal representative will be signing for the individual, checking the "Check here for legal representative" will add the appropriate section.



**Authorization for Disclosure, Sharing and Use of Individual Information**

Save As | Reset | Print

Show instruction pages
Hide instruction pages

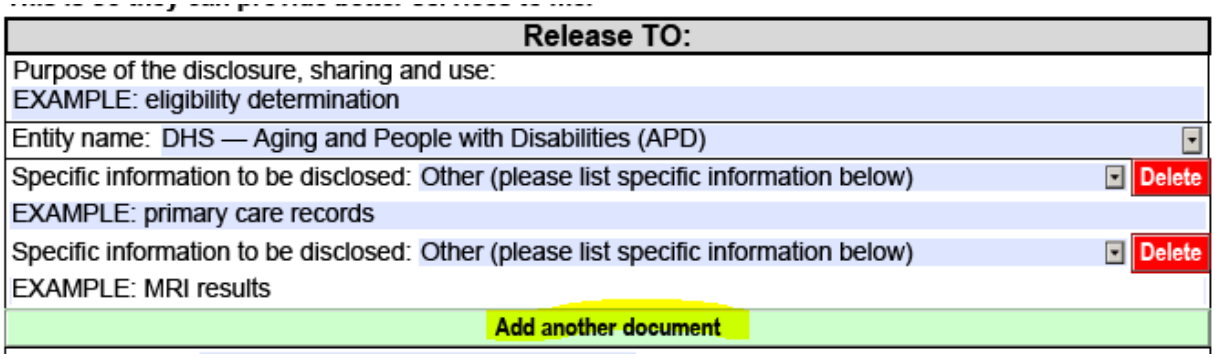
**This form** allows the referral, coordination and oversight of provider services.

☒ Check here to add a legal representative

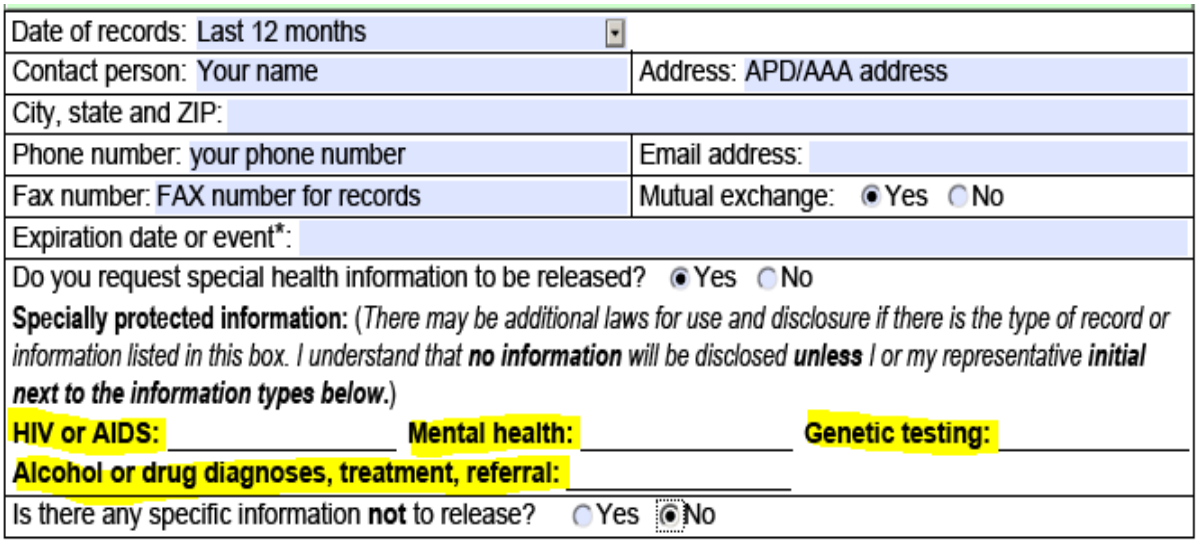
| **Legal last name:** | **First name:** | MI: | Date of birth: |
|---|---|---|---|
| Other names: | | | |
| Address: | City: | State: | ZIP: |
| Phone: | Email address: | | |
| Identification type: Prime ID: | | | |
| **Legal last name of representative (*if any*):** | **First name:** | MI: | |
| Relationship to the person listed above: | | | |
| Address: | City: | State: | ZIP: |
| Phone: | Email address: | | |

**When I sign this form, I authorize those I name to give specific personal information about me. If I answer "yes" to "mutual exchange," I allow agencies I name to share information back and forth. This is so they can provide better services to me.**

In general, the information provided under the section of "Release to" will be the entity that requires the information. In the example provided below, the request is for a DHS eligibility determination. Please note that if more than one type of record is requested, clicking on the "add another document" will add additional spaces to list other types of information that is requested (see highlighted).




Provide your contact information including a fax number so that records may come securely via fax. If there is a need for any special category of information listed in the section below, the individual MUST initial next to the section (see highlighted).




The "Release from" section should be the entity that the records or information is needed from. In the example provided below, DHS is requesting records from a primary care provider. The provider's information will be filled in here and in most cases, a fax number to the medical records department of a hospital or the provider's office is very important as many provider use fax as their primary way to accept record requests. If records are needed from multiple providers, clicking the sections of "add a releasing entity" will provide a blank sections for you to add the next provider's information. **Although this feature allows for multiple providers on a single form, best practice is for each provider to be listed on a separate form.** Many providers will not release records if other providers are listed on the same form**.**

The 3010 is also used to authorize the Department to speak with family members and share requested case information.

| Release FROM: | |
|---|---|
| **Purpose of the disclosure, sharing and use:** EXAMPLE: eligibility determination | |
| Entity name: Other (type name here):Providence Health Primary Care (example) | |
| Specific information to be disclosed: Other (please list specific information below) Delete | |
| Primary care records | |
| **Add another document** | |
| Date of records: Last 12 months | |
| Contact person: Dr. Joan Smith | Address: Provider's address |
| City, state and ZIP: Provider's address | |
| Phone number: Provider's contact | Email address: Provider's contact |
| Fax number: FAX number is IMPORTANT | Mutual exchange: ◉ Yes ○ No |
| Expiration date or event*: will expire in ONE YEAR unless specified | |
| Is there any specific information **not** to release? ○ Yes ◉ No | |
| **ADD** a releasing entity | **REMOVE** this releasing entity (*above*) |
| **Purpose of the disclosure, sharing and use:** | |
| Entity name: Pick one | |
| Date of records: Pick one | |
| Contact person: | Address: |
| City, state and ZIP: | |
| Phone number: | Email address: |
| Fax number: | Mutual exchange: ○ Yes ○ No |
| Expiration date or event*: | |
| Is there any specific information **not** to release? ○ Yes ○ No | |
| **ADD** a releasing entity | **REMOVE** this releasing entity (*above*) |

Finally, the individual authorizing the release of information must acknowledge and sign the 3010. If it is a legal representative, they must provide evidence of their ability to sign on behalf of the person. The 3010 is not valid without the signature page.

**Your 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 any listed:
  » Agency » Business » Organization » Person
- This authorization is valid for one year from the date I sign it unless otherwise noted.*
- I understand my representative or I can cancel this authorization. However, information shared before I cancel cannot be undone. I can orally cancel an authorization for drug and alcohol information. All other cancellation requests must be written. I must provide any request to cancel to the agency, business, organization or person that is providing the information.
- I understand that federal or state law prohibits re-disclosure of the following, without authorization by me or my representative:
  » Drug and alcohol diagnosis » HIV and AIDS information » Mental health
  » Referral information » Treatment records » Vocational rehabilitation records
- I understand that information that does not have re-disclosure restrictions may be re-disclosed. Re-disclosed information 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. They may also need to get more information.
- I understand that deciding not to sign this form may:

| | |
|---|---|
| » Prevent agencies from deciding if I am eligible for certain programs.<br>» Prevent me from getting referrals. It may also make coordination of provider services more difficult.<br>» Affect my ability to get health services if it is necessary to share information.<br>» Keep the Oregon Health Plan (OHP) or Medicaid from paying for a service because they do not have authorization.<br>**- I am signing this authorization of my own free will.** | |
| **Signature:** | |
| Printed name: | Date: |
| **Signature of legal representative (*if any*):** | |
| Printed name: | Date: |
| *If the person legally authorized to act for the person on this form signs, they must give evidence of their authority to do so.* | |

Other permissible and prohibited disclosures of information that apply to APD/AAAs are outlined in the following links: https://apps.state.or.us/Forms/Served/oha100-002.pdf and APD IM 18-089.

*If you have any questions about this information, contact:*

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|---|---|
| Contact(s): Darla Zeisset | |
| Phone: 503-779-8983 | Fax: |
| Email: darla.p.zeisset@dhsoha.state.or.us | |