# *AUTHORIZATION FOR RELEASE OF INFORMATION*

**I. Information About the Use or Disclosure**

**I _____ hereby authorize the use or disclosure of my individually identifiable health/ personal information as described below. / *understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.***

**Employee Name Requesting Information from the Organization: _____**

**Employee Name Releasing Information from the Organization**: _____

**Person/organizations authorized to provide/share information: *Oregon Health Authority Office of Equity and Inclusion***

**Persons/organizations authorized to receive information:_____**
**Specific purpose of the disclosure: _____**

**This authorization expires on (indicate date, or an event relating to you personally or to the purpose of the authorization): _____**

**II. Important Information About Your Rights. I have read and understand the following statements about my rights:**

- ◯ I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.
- ◯ I may see and copy the information described on this form if I ask for it.
- ◯ I am not required to sign this form to receive services or assistance from YE or its subsidiary programs.
- ◯ The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive information that they will not redisclose the information to any other party without my further authorization.

**III. Signature of Client or Client's Representative: (***Form MUST be Completed before signing)*

_____ _____

**Signature (Client, Guardian, or person authorized to sign on behalf of the client** **Date:**

_____

**Printed Name of Requesting person and relationship to client** **Email: _____**
**Date: _____**

***Oregon Health Authority Office of Equity and Inclusion will retain a Copy on File***
***EMAIL TO: thw.program@dhsoha.state.or.us***