

DESCHUTES COUNTY HEALTH SERVICES - DEVELOPMENTAL DISABILITY PROGRAM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

2577 NE Courtney Drive, Bend OR 97701 Phone: 541-322-7554 Fax: 541-330-4636

Client Name: _____ DOB: _____

Maiden and/or Other Names Used: _____

I authorize the individuals or agencies marked below to disclose to, and exchange with, Deschutes County Health Services/IDD Program, Protected Health Information (PHI) about client for the purposes of planning, coordinating, providing or monitoring services for me or my family, and for any of the following other specified purposes: _____

<input type="checkbox"/> COPA <input type="checkbox"/> BMC-Summit Medical <input type="checkbox"/> St. Charles Health System / PEDAL Clinic <input type="checkbox"/> Mosaic Community Health <input type="checkbox"/> Mindsights <input checked="" type="checkbox"/> Other Medical Providers: Please list: <input checked="" type="checkbox"/> Parent(s): <input type="checkbox"/> <input type="checkbox"/>	<input checked="" type="checkbox"/> _____ School District <input checked="" type="checkbox"/> Department of Human Services (DHS) Self-Sufficiency Program (AFS) Child Welfare Services Seniors & People with Disabilities (SPD) Volunteer Services Vocational Rehabilitation <input checked="" type="checkbox"/> IDD Administrative Evaluation providers (Shank; Oxtoby; <input type="checkbox"/> Saccoman; PsychNW, Kriz; Warner and Marshall) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

I understand and agree that the types of information marked below may be disclosed/exchanged:

<input checked="" type="checkbox"/> DD Eligibility Statement	<input checked="" type="checkbox"/> Individual Service Plans (ISPs)
<input checked="" type="checkbox"/> Case Management Plan	<input checked="" type="checkbox"/> Child and Family Support Plans
<input checked="" type="checkbox"/> Progress notes (specify dates: _____)	<input checked="" type="checkbox"/> Cognitive and Adaptive Evaluation(s)
<input checked="" type="checkbox"/> Psychological testing	<input type="checkbox"/> _____
<input checked="" type="checkbox"/> Individual Education Plans (IEPs)	<input type="checkbox"/> _____

I understand and agree that the following types of information may also be disclosed or exchanged, but ONLY if I place my initials in the space next to the information:

Psychiatric/Mental Health records: Genetic testing information:
 HIV/AIDS : Drug/Alcohol diagnoses, treatment, referral:

ACKNOWLEDGEMENT	<p>I understand that this authorization is valid for one year, unless otherwise specified. I understand that I can cancel this authorization at any time by providing written notice of cancellation to the above-identified record holder(s). Such cancellation will not affect any information that was already disclosed. I understand I may refuse to sign this form.</p> <p>I understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected under federal or state law, EXCEPT THAT redisclosure by the recipient of information related to HIV/AIDS, mental health, alcohol or drug treatment, or genetic testing information is prohibited without my authorization unless otherwise permitted by federal or state law.</p> <p>I understand that Client's personal health information is confidential and may be protected by state and federal laws, and I approve the release of Client's personal health information in accordance with this authorization. I am signing this authorization voluntarily and without pressure or coercion. I acknowledge that I have been offered a copy of this form, and that I have been provided a copy of Deschutes County's written "Privacy Practices Notice."</p>
------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Signature _____ Date _____ Witness _____ Date _____

Signator's relationship to Client: Client Legal Guardian* *Legal guardianship paperwork in client's file; will provide upon request".

INITIATING AGENCY

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other applicable laws. This is a

(Agency staff person)

true copy of the original authorization document _____ Date: _____

(Agency staff person)

DCMH Form #20 DD
Adult Rev 07/24