**DESCHUTES COUNTY MENTAL HEALTH - DEVELOPMENTAL DISABILITY PROGRAM**

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR ADULTS**

1340 NW Wall St. Bend, OR 97701 Phone: 541-322-7554 Fax: 541-330-4636

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| --- | --- | --- | --- | --- | --- | --- |
| Client Name: |  | | DOB: |  | Social Security: |  |
| Maiden and/or Other Names Used: | |  | | | | |

I authorize the individuals or agencies marked below to disclose to, and exchange with, Deschutes County Behavioral Health Department, 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  | Medical Providers |  |  |  | School District |
|  |  |  |  |  | C.O. Regional Housing Authority (CORHA) |
|  |  |  |  |  | Pacific Source Community Solutions (PSCS) |
|  |  |  |  |  | Department of Human Services (DHS) |
|  | Social Security Administration |  |  |  | Self-Sufficiency Program (AFS) |
|  | Opportunity Foundations (OFCO) |  |  |  | Child Welfare Services |
|  | Full Access (FA) |  |  |  | Seniors & People with Disabilities (SPD) |
|  | Abilitree (Formerly CORIL) |  |  |  | Volunteer Services |
|  | Central Oregon Collective |  |  |  | Vocational Rehabilitation |
|  | Cascade Regional Crisis Resolution Team |  |  |  | Deschutes County Adult Community Justice |
|  |  |  |  |  | Deschutes County Health Department |
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I understand and agree that the types of information marked below may be disclosed/exchanged:

DD Eligibility Statement Individual Service Plans (ISPs)

Case Management Plan  Child and Family Support Plans

Progress notes (specify dates: ) Cognitive and Adaptive Evaluation(s)

Psychological testing

Individual Education Plans (IEPs)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **ACKNOWLEDGEMNT** | 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.  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.  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. |

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 true copy of the original authorization document Date:

DCMH Form #20

DD Adult Rev 4/16

(Agency staff person)