|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Child’s Name: |  | DOB: |  | Social Security: |  |

I authorize the individuals or agencies marked below to disclose to, and exchange with, Deschutes County Behavioral Health Department, Protected Health Information (PHI) of the above-identified child for the purpose of planning, coordinating, providing and monitoring services for the child and his/her family, and for any of the following other specified purposes:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Medical Providers | |  |  |  | School District |
|  |  | |  |  |  | Education Service District (ESD )Services |
|  |  | |  |  |  | Department of Human Services (DHS) |
|  |  | |  |  |  | Self-Sufficiency Program (AFS) |
|  | Hospital |  |  |  |  | Child Welfare Services |
|  | Deschutes Cty Health Department | |  |  |  | Aging & People with Disabilities (SPD) |
|  | Social Security Administrations | |  |  |  | Volunteer Services |
|  | Abilitree | |  |  |  | Vocational Rehabilitation |
|  | Central Oregon Collective | |  |  |  | Pacific Source Community Solutions (PSCS) |
|  | Opportunity Foundation | |  |  |  | Deschutes Cty Juvenile Community Justice |
|  | 1st Choice Assisted Care | |  |  |  |  |
|  | Potential Personal Support Workers (PSW) | |  |  |  |  |
|  | Cascade Region Crisis Resolution Team | |  |  |  |  |
|  |  | |  |  |  |  |
|  |  | |  |  |  |  |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | DD Eligibility Statement | |  | Individual Service Plans (ISP’s) |
|  | Case Management Plan | |  | Cognitive and Adaptive Evaluations |
|  | Progress Notes - specify dates: |  |  | Child and Family Support Plans |
|  | Psychological testing | |  |  |
|  | Individual Education Plans (IEP’s) | |  |  |

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 Child’s personal health information is confidential and may be protected by state and federal laws, and I approve the release of Child’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 child:  Parent  Guardian\*  Legal Custodian \* (\*guardianship/custody documentation in file/provided per 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 children Rev 4/16