DHS Oregon Department of Human Services

Authorization for Use and Disclosure of Individual Information

Oregon Health Authority

Legal last name of individual:	First name:	MI:	Date of birth:
Other names used by individual:			
○ Prime ID / ○ Case number / ○ SSN:			
Legal last name of representative:	First name:		MI:

By signing this form below, I authorize the named record holder to disclose the following specific confidential information about me.*

RELEASE FROM	
Release from one record holder: (*Individual, school, employer, agency, medical or other provider.*)	
Full name: 4J School District	Address: 200 Monroe St
City, state and ZIP: Eugene, OR 97402	
Email address: Allan Chinn (chinn@4j.lane.edu)	Phone number: 541-790-7700
Specific information to be disclosed: (*Please be as detailed as possible. Requesting "all information" could delay the response.*) School records, attendance, grades, incidental information, Child Welfare and Self Sufficiency Program information (if applicable)	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information***.) **HIV/AIDS:** √ **Mental health:** √ **Genetic testing:** √ **Alcohol/drug diagnoses, treatment, referral:**	

RELEASE TO	
Release to: (*Address required if mailed.*) 4J Student Care Team	
Full name: 4J; Dept. of Human Services- Self Sufficiency Prog. & Child Welfare; Dept. of Youth Services; Family Support and Connections (Catholic Community Services)	Address: 4J School District 200 N Monroe Street
City, state and ZIP: Eugene, OR 97402	
Phone number: 541-790-7700	Email address: Allan Chinn (chinn@4j.lane.edu)
Purpose of the requested use or disclosure: Family Support, resources, referrals and assistance	
Expiration date or event*:	Mutual exchange: ◉ Yes ○ No

**This authorization is valid for one year from the date of signing unless otherwise specified*

CLIENT ACKNOWLEDGMENT
• I was given the opportunity to ask questions about this form and what it does. • I understand that state and federal law protect information about services I receive from DHS|OHA. I understand what this agreement means and I approve of the disclosures or releases listed. • I understand that I can revoke (*cancel*) this authorization at any time and revocation (*cancellation*) will not apply to any information already disclosed or released. Except for drug and alcohol information, the individual or a person legally authorized to act on behalf of the individual is required to submit the cancellation request in writing. Oral or written notification of the revocation of authorization for drug and alcohol information shall be accepted. Any request for revocation must be provided to your local DHS or OHA program or local branch office. • I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information, or vocational rehabilitation records without specific authorization. • I understand that the information not subject to limitations on re-disclosure as noted immediately above may be subject to re-disclosure and no longer protected under federal or state law. • **I am signing this authorization of my own free will.**
Full legal signature of individual or a person legally authorized to act on behalf of the individual:

Relationship to individual:	Phone number:	Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.		

Do not complete section below unless a true copy of the original authorization is required.

FOR AGENCY USE ONLY		
Name of staff person (*print*):	Initiating agency name/location:	Date:
Legal signature of agency staff certifying true copy:		

Initial and date if form has been copied:

Required information for the individual

Declining to sign may:

- Prevent DHS and OHA from determining eligibility for programs administered by DHS and OHA.
- Affect the ability of DHS and OHA to refer and coordinate services with providers.
- Affect the ability of the individual to receive services if the purpose of this form is to provide information necessary to receive health services.
- Affect payment for services if DHS or OHA is a provider of or paying for health care services under the Oregon Health Plan or Medicaid Program and DHS or OHA require the authorization to get reimbursement.

Instructions for Use and Disclosure of Individual Information Form MSC 2099

RELEASE FROM	
Release from	• A record holder's name must be specific. For example, listing "medical" or "service provider" is not adequate. Please list the name of the medical or service provider. For an individual or other type of organization, such as a school or employer, list the name of the individual or other type of organization.
Specific information to be disclosed	• Some examples of specific information are assessments, treatment plans, results of urinalysis, psychological reports, financial information, case plans and Medicaid billing summary. • Do not indicate "entire record" unless it is necessary to accomplish the purpose. (*See the "RELEASE TO" section below for definition of "Purpose".*)
Specially protected information	• A check mark in the space next to the information is not sufficient; initials must be placed in the space next to the information if the individual agrees to release this information.
RELEASE TO	
Release to	• The individual must be given the option to complete a separate form for each entity. • If the purpose of the form is the release of records to DHS|OHA the individual shall be provided a copy of the completed form. • If a single form is used for multiple entities the individual should be given the option to limit the information disclosed to each entity or refuse disclosure to a particular entity or individual on the list. • The authorization form can be pre-printed with standard multidisciplinary team members, as long as the individual is given the option to omit one or more team members. • If the release is to a subsection, program, or team of a larger organization, be specific as to who should receive the information. • If the individual only wants to release information to a certain member(s) of a team, be specific as to which team and member(s).
Purpose of the requested use or disclosure	• The stated purpose should describe the specific need for the disclosure requested in the "RELEASE FROM" section. • DHS|OHA may include the statement "at the request of the individual" as the purpose when an individual initiates the authorization and does not choose to provide a statement in the "Purpose" section.
Expiration date or event	• This authorization is valid for one year from the date of signing unless a specific expiration date or expiration event such as "hospital discharge" or "end of litigation" is specified.
Mutual exchange	• A "yes" allows the specific information on the form to go back and forth between the record holder and the people or programs listed on the authorization. Mutual exchange does not open all records for discussion between the record holder and the record requester. • Only when a mutual exchange is requested, the individual can choose to list multiple entities in the "RELEASE TO" section. • To add additional "RELEASE TO" sections, use the ADD or REMOVE buttons before printing the form.
Re-disclosure	• Re-disclosure is the disclosure of information by the recipient. • There may be restrictions on the re-disclosure of information released under this form. • Federal and state regulations prohibit re-disclosure of alcohol and drug, and HIV/AIDS information without specific authorization.

CLIENT ACKNOWLEDGMENT	
Full legal signature of individual, or a person legally authorized to act on behalf of the individual	• An individual, or person legally authorized to act on behalf of the individual should never be asked to sign a blank or incomplete authorization form. • When submitting the form, it is not necessary to send the "Instructions for Use and Disclosure of Individual Information Form MSC 2099" section.
FOR AGENCY USE ONLY	
Agency staff use	• Agency staff signature confirms that this is a true copy of the original authorization document. • DHS|OHA shall maintain a copy of the completed authorization form either electronically or in paper file in accordance with agency retention schedules. • If completed authorization forms are stored electronically, a process shall be in place for revocation. If a signed authorization is later revoked (*cancelled*) that revocation shall be noted electronically. • Do not use labels on the authorization form. • When completed properly, the form is able to stand alone to process a requested disclosure.

To request records from DHS:	To request records from OHA, send form to:
Contact your program area or local branch office	Oregon Health Authority Director's Office Authorization to Disclose Records 500 Summer St. NE, E20, Salem, OR 97301 Phone: 503-945-6292 (TTY: 711) Fax: 503-378-2897