



# Authorization for Disclosure, Sharing and Use of Individual Information

This form allows the referral, coordination and oversight of provider services.

<b>Legal last name:</b> Child	<b>First name:</b>	<b>MI:</b>	<b>Date of birth:</b>
Other names:			
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>ZIP:</b>
<b>Phone:</b>	<b>Email address:</b>		
Identification type: Pick one			
<b>Legal last name of representative (if any):</b> Parent/Guardian	<b>First name:</b>	<b>MI:</b>	
Relationship to the person listed above:			
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>ZIP:</b>
<b>Phone:</b>	<b>Email address:</b>		

**When I sign this form, I authorize those I name to give specific personal information about me. If I answer "yes" to "mutual exchange," I allow agencies I name to share information back and forth. This is so they can provide better services to me.**

Release TO:	
Purpose of the disclosure, sharing and use: Family Support, resources, referrals, collaboration and assistance	
Entity name: North/Howard Student Care Team- 4J School District	
Date of records: Last 24 months	
Contact person: Principal Allan Chinn	Address: Howard Elem. 700 Howard Avenue
City, state and ZIP: Eugene OR 97404	
Phone number: 541-790-4900	Email address: chinn@4j.lane.edu
Fax number:	Mutual exchange: <input checked="" type="radio"/> Yes <input type="radio"/> No
Expiration date or event*: one year	
Do you request special health information to be released? <input checked="" type="radio"/> Yes <input type="radio"/> No	
<b>Specially protected information:</b> (There may be additional laws for use and disclosure if there is the type of record or information listed in this box. I understand that <b>no information</b> will be disclosed <b>unless</b> I or my representative <b>initial next to the information types below.</b> )	
<b>HIV or AIDS:</b> _____	<b>Mental health:</b> _____ <b>Genetic testing:</b> _____
<b>Alcohol or drug diagnoses, treatment, referral:</b> _____	
Is there any specific information <b>not</b> to release? <input type="radio"/> Yes <input checked="" type="radio"/> No	

Release FROM:
<b>Purpose of the disclosure, sharing and use:</b> Family support, resources, referrals, collaboration, assistance
Entity name: North/Howard Care Team: Dept. of Human Svs- Self Sufficiency Program & Child Welfare
Specific information to be disclosed: Other (please list specific information below) case plans, attendance, public assistance, case history, current worker (if applicable)

Date of records: Last 24 months	
Contact person: Terra Ralph	Address: 2885 Chad Drive
City, state and ZIP: Eugene OR 97408	
Phone number: 541-684-2580	Email address: terra.l.ralph@dhsosha.state.or.us
Fax number:	Mutual exchange: <input checked="" type="radio"/> Yes <input type="radio"/> No
Expiration date or event*: one year	
Is there any specific information <b>not</b> to release? <input type="radio"/> Yes <input checked="" type="radio"/> No	

### Your acknowledgment

- I was given the chance to ask questions about this form and what it does.
- I understand what this form means and I approve of the disclosures or releases listed.
- I understand that state and federal law protect information about services I receive from any listed:
  - » Agency
  - » Business
  - » Organization
  - » Person
- This authorization is valid for one year from the date I sign it unless otherwise noted.\*
- I understand my representative or I can cancel this authorization. However, information shared before I cancel cannot be undone. I can orally cancel an authorization for drug and alcohol information. All other cancellation requests must be written. I must provide any request to cancel to the agency, business, organization or person that is providing the information.
- I understand that federal or state law prohibits re-disclosure of the following, without authorization by me or my representative:
  - » Drug and alcohol diagnosis
  - » HIV and AIDS information
  - » Mental health
  - » Referral information
  - » Treatment records
  - » Vocational rehabilitation records
- I understand that information that does not have re-disclosure restrictions may be re-disclosed. Re-disclosed information may no longer be protected under federal or state law.
- I understand someone may need to contact me about this form to confirm my identity. They may also need to get more information.
- I understand that deciding not to sign this form may:
  - » Prevent agencies from deciding if I am eligible for certain programs.
  - » Prevent me from getting referrals. It may also make coordination of provider services more difficult.
  - » Affect my ability to get health services if it is necessary to share information.
  - » Keep the Oregon Health Plan (OHP) or Medicaid from paying for a service because they do not have authorization.
- **I am signing this authorization of my own free will.**

**Signature:**

Printed name:

Date:

**Signature of legal representative (if any):**

Printed name:

Date:

*If the person legally authorized to act for the person on this form signs, they must give evidence of their authority to do so.*

### Security statement

This form may contain your personal information. If you return the form by email there is some risk it could go to someone you don't want to have the information. If you are not sure how to send a secure email, consider using regular mail or fax.

*For questions or help to complete this form, please contact the agency you work with.*

- Oregon Health Authority: 503-947-2340
- Oregon Department of Human Services: 503-945-5600
- Oregon Commission for the Blind: 971-673-1588
- Oregon Department of Employment: 800-237-3710
- Oregon Department of Education: 503-947-5600
- Oregon Housing and Community Services: 503-986-2000
- Oregon Department of Justice: 503-378-4400
- Oregon Department of Corrections: 503-945-9090
- Oregon Youth Authority: 503-373-7205
- Oregon State Police: 503-378-3720

*\* This authorization is valid for one year from the date I sign it, unless otherwise noted.*

## Instructions by section

When you submit the form, you do not need to include the instruction pages.

### Creating preset templates

To save time, you can preset the number and type of sections. You can also prefill your organization's information, then save template versions of this form for quick printing. Use the non-printing "Template" field in the top right corner of the form and name the template for your future reference.

### Release TO and FROM sections

Purpose of disclosure, sharing and use	<ul style="list-style-type: none"> <li>• Give specific reasons why the information disclosure, sharing and use are needed.</li> <li>• If the person does not want to provide a reason in this field the requesting entity may include the statement "at the request of the person" as the purpose the person initiates the authorization.</li> </ul>
Entity name (drop-down list)	<ul style="list-style-type: none"> <li>• Choose an entity from the drop-down list.</li> <li>• If the entity is not listed, choose "Other (please type in here):" Then, type in the entity's name. An entity'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 a person or other type of organization, such as a school or employer, list the name of the person or other type of organization.</li> </ul>
Specific information to be disclosed ( <i>pops up after an entity is selected</i> )	<ul style="list-style-type: none"> <li>• Choose a document type from the drop-down list.</li> <li>• If an information type is not listed, choose "Other (please type in here):" and type in a description. Some examples of specific information are: <ul style="list-style-type: none"> <li>» Assessments</li> <li>» Case plans</li> <li>» Financial information</li> <li>» Medicaid billing summaries</li> <li>» Psychological reports</li> <li>» Results of urinalysis</li> <li>» Treatment plans</li> </ul> </li> <li>• Do not indicate "entire record" unless it is necessary to accomplish the purpose (see "Purpose of the disclosure, sharing and use", above).</li> <li>• Use the buttons to add or delete additional requested information types, if you need to.</li> </ul>
Date of records	<ul style="list-style-type: none"> <li>• Indicate the specific date range for the requested records.</li> </ul>
Expiration date or event	<ul style="list-style-type: none"> <li>• This authorization is valid for one year from the date I sign, unless otherwise noted. For example, if "hospital discharge" or "end of litigation," is noted.</li> </ul>
Mutual exchange	<ul style="list-style-type: none"> <li>• A "Yes" allows the specific information listed on the form to go back and forth between the record holder and the people or programs listed on this authorization. Mutual exchange opens all requested records for discussion between the record requestor and specified record holders.</li> </ul>
Did you request special health information to be released?	<ul style="list-style-type: none"> <li>• Choosing "Yes" will display a section where special health information types can be stated.</li> <li>• A check mark in the space next to the type of health information is not enough. The person must initial the space next to the information if they agrees to release this information.</li> <li>• If you need this section visible in a printed copy, please make sure to choose "Yes" prior to printing.</li> </ul>
Is there any specific information <b>not</b> to release?	<ul style="list-style-type: none"> <li>• A "Yes" choice will display a text box where you can list specific information.</li> <li>• If any specific information should not be included when the records are released, please list them here.</li> <li>• If you need this section visible in a printed copy, make sure to choose "Yes" before to printing.</li> </ul>

Re-disclosure	<ul style="list-style-type: none"> <li>• Re-disclosure is the disclosure of information by the person on this form.</li> <li>• There may be restrictions on the re-disclosure of information released under this form.</li> <li>• Federal and state regulations prohibit re-disclosure of alcohol and drug, and HIV or AIDS information without specific authorization.</li> </ul>
Adding requesting and releasing entities	<ul style="list-style-type: none"> <li>• If there is a need for multiple requesting or releasing entities, use the ADD or REMOVE buttons to add or remove any additional "Releasing agency, business, organization or person" sections before you print the form.</li> </ul>

**Client acknowledgment section**

Signature of the person on this form or a person legally authorized to act for them.	<ul style="list-style-type: none"> <li>• A person legally authorized to act for the person on this form should never be asked to sign a blank or incomplete authorization form.</li> </ul>
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**Releasing entity: Document when records were shared.**

<ul style="list-style-type: none"> <li>• Entity must: <ul style="list-style-type: none"> <li>» Maintain a copy of the completed authorization form, either electronically or in paper file, and</li> <li>» Following agency retention schedules.</li> </ul> </li> <li>• If completed authorization forms are stored electronically, a process shall be in place for cancellation. If a signed authorization is later (<i>cancelled</i>), that revocation must be noted electronically.</li> <li>• Do not use labels on the authorization form.</li> <li>• When completed correctly, the form is the only thing needed to process a disclosure.</li> </ul>
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