Health and Human Services Department

Adult Programs
Developmental Disabilities
Family and Youth Programs
Public Health Programs

Authorization for Use and Disclosure of Information

This form is available in alternative formats including Braille, large print, computer disk and oral presentation.

Legal last name of client/applicant:	**First:**	**MI:**	**Date of Birth:**
Other names used by client/applicant:			**Case ID number:**

By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:

Release from one record holder: *(individual, school, employer, agency, medical or other provider)*	**Release To:** *(Address required if mailed. If releasing to a team, list members)*
Yamhill County Adult Behavioral Health	**Type: CCS Court** **Yamhill County District Attorney's Office** **Yamhill County Department of Community Justice** **Yamhill County Circuit Court** **Supervisory Authority/Board** **Treatment Provider:** **My Attorney:** **Other:**

This authorizes information exchange between the parties as follows: Mutually between Yamhill County and other party

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

Mental Health:		Alcohol/drug diagnoses, treatment, referral:		HIV/AIDS:		Genetic Testing:	

Specific Information to be Disclosed:	**Purpose:**
Abstinence Monitoring/UA Results Aftercare Treatment Recommendations Behavioral Health Assessment Behavioral Health Service Plan Diagnostic Impression & Diagnosis Progress & Treatment Recommendations Reason for Service Conclusion Treatment dates, status & progress Incident Reports	Coordination of services to determine eligibility and/or acceptability for mental health and/or substance abuse services

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

Expiration date or event: Upon completion or withdrawal from the treatment program or end of supervision

Signature & Copies:

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will. I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, mental health and drug/alcohol diagnosis, treatment, vocational rehabilitation records or referral information without specific authorization.

Full legal signature of individual or authorized personal representative:	**Relationship to client:**	**Date:**
	☐ Legal Rep. Documentation on File	
Name of staff person (print):	**Initiating agency name/location**	**Date:**
Full legal signature of agency staff person printing/making copies:	**Printed Name of Staff Person:**	**Date:**
This is a true copy of the original authorization document.		

See "Required Information" on page 2 of this form.
(not valid without page 2)

Required information for the client

To provide or pay for health services: If the Yamhill County Health and Human Services (YCHHS) is acting as a **provider** of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. *(Examples of this would be assessments, tests or evaluations.)* Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.
This is a voluntary form. YCHHS cannot condition the provision of treatment, payment or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Using this form

1. **Terms used: Mutual exchange:** A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, a YCHHS staff person should fill out this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
3. **Guardianship/custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody and their representative signs, their custody authority must be attached to this form.
4. **Cancel:** If you later want to cancel this authorization, contact your YCHHS staff person. You can remove a team member from the form. You will be asked to put the cancellation request in writing.
   Exception: Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. YCHHS can continue to use information obtained prior to cancellation.
5. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
6. **Special attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed and the purpose.
7. **Photocopying:** Keep the original on file and send copies to other agencies. The person making the photocopies should sign each copy at the bottom of the first page certifying that it is a true copy. The agency receiving the authorization should reject it if there is not an original signature by the person who made the copy.

Redisclosure:
Federal regulations (42 CFR part 2) prohibit making any further disclosure of alcohol and drug information:
"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]"
State law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-22-0210); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization