JACKSON COUNTY
Oregon

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Federal and Oregon laws require a patient or authorized patient representative to give written permission for certain uses and disclosures of protected health information. Please complete this form to give this permission.

Patient Name: _____ **Date of Birth:** _____

Person or Entity Authorized to Disclose Information: 45 CFR § 164.508(c)(ii)
(Who do you want to release the information? Please place a check mark beside each person or entity authorized to release information.)

Agency/Person Initiating Form: Jackson County Mental Health Court

☐ Department of Human Services: Child Welfare	☐ LaClinica
☐ Jackson County Health and Human Services	☐ Rogue Community Health (or Community Health Center)
☐ Jackson County Community Justice	☐ Community Works/Dunn House
☐ Jackson County Sheriff's Office	☐ Veterans' Administration
☐ Jackson County District Attorney's Office	☐ Medford Police Department
☐ Addictions Recovery Center	☐ State of Oregon Judicial Department
☐ Asante	☐ St. Vincent de Paul
☐ OnTrack Inc.	☐ Gospel Mission
☐ Salvation Army	☐ Providence Hospital
☐ Southern Oregon Public Defender, Inc.	☐ Conmed
☐ Los Abogados (Indigent criminal defense)	☐ Other (please specify):
☐ Other (please specify):	☐ Other (please specify):

Information to be Used or Disclosed: 45 CFR § 164.508(c)(i)
(What information do you want the person or entity authorized above to disclose?)

☐Mental health assessments/evaluations, referrals and diagnoses	☐Substance abuse assessments/evaluations and referrals
☐Mental health treatment records	☐Substance abuse treatment records
☐Urinalysis/substance abuse testing results	

Recipient of Information to be Use or Disclosed: 45 CFR § 164.508(c)(iii)
(Who is authorized to use or receive the information authorized above to be disclosed?)

☐ Jackson County Mental Health	☐ Medford Police Department
☐ Jackson County Community Justice	☐ State of Oregon Judicial Department
☐ Jackson County Sheriff's Office	☐ Other (please specify):
☐ Jackson County District Attorney's Office	☐ Addictions Recovery Center
☐ Southern Oregon Public Defender, Inc.	☐ OnTrack Inc.
☐ Self	☐ Other (please specify):
☐ Other (please specify):	☐ Other (please specify):

Reason for Disclosure: 45 CFR §164.508(c)(iv)
(What may the person authorized above to receive the information do with the information?)

☐ At the request of the individual	☐ Other:

Disclosure of Specific Types of Information: 45 CFR §164.509(a)2); ORS 433.045.

I understand that federal or state law may restrict the redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. Therefore, I understand and agree that these types of information **will only be disclosed** if I placed my **INITIALS** in the appropriate space next to that type of information. If I do not place my **INITIALS** next to a specific type of information, then I understand and agree that type of information **WILL NOT BE DISCLOSED**.

Participation in Mental Health Court requires disclosure of mental health information and drug/alcohol diagnosis, treatment and referral information. If you consent to this disclosure please initial below.

_____ HIV/AIDS information	_____ Genetic testing information
_____ Mental Health information	_____ Drug/alcohol diagnosis, treatment or referral information

REQUIRED STATEMENTS

1. The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal or state law (although federal or state law may restrict disclosure of the sensitive information described above; **45 CFR § 164.508(c)(2)(iii)**.
2. Refusal to sign this authorization will not adversely affect your ability to receive health care services or reimbursement for services. The consequences to the individual of a refusal to sign this authorization are that the patient's health information may not be released as requested. **45 CFR § 164.508(c)(2)(ii).**
3. You may **revoke** this authorization in writing at any time. If you revoke this authorization, the information described above may no longer be used or disclosed for the purposed described in this authorization. The only exception is when a covered entity has taken action in reliance on this authorization or the authorization was obtained as a condition of obtaining insurance. **45 CFR § 164.508(c)(2)(ii).**

To revoke this authorization, please send a written statement indicating your revocation to:

NAME	Jackson County Mental Health Court Coordinator
ADDRESS	Justice Building
CITY, STATE, ZIP	100 S. Oakdale Avenue, Medford, OR 97501-3127
TELEPHONE	541-776-7171 ext. 215
FAX	541-776-7057

4. **THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR AFTER THE DATE IT IS SIGNED UNLESS YOU WRITE A DIFFERENT EXPIRATION DATE OR EVENT HERE: withdrawal or graduation from Mental Health Court. 45 CFR § 164.508(c)(v).**

I HAVE READ THIS AUTHORIZATION AND UNDERSTAND IT:

PATIENT SIGNATURE: _____ **DATE:** _____

PRINTED NAME OF PATIENT: _____

PERSONAL REPRESENTATION SIGNATURE (if applicable): _____

PRINTED NAME OF PERSONAL REPRESENTATIVE (if applicable): _____

RELATIONSHIP OF PERSONAL REPRESENTATIVE TO PATIENT: _____

WITNESS SIGNATURE (required): _____

PRINTED NAME OF WITNESS (required): _____

LIMITATION ON FEES FOR COPIES

Pursuant to ORS 192.563, a health care provider or state health plan that receives an authorization to disclose protected health information may charge:
(1)(a) No more than $30 for copying 10 or fewer pages of written material, no more than 50 cents per page for pages 11 through 50 and no more than 25 cents for each additional page; and
(b)A bonus charge of $5 if the request for records is processed and the records are mailed by first class mail to the requester within seven business days after the date of the request;
(2)Postage costs to mail copies of protected health information or an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual; and
(3)Actual costs of preparing an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual.