CLATSOP BEHAVIORAL HEALTHCARE

# Release of Information

Authorization for Use and Disclosure of Protected Health Information

Name:_____ DOB:_____ SSN#:_____

Other Names Used:_____

**By signing this form, I am allowing Clatsop Behavioral Healthcare (CBH) to exchange my health information, as follows:**

The individual or agency authorized to exchange my health information with Clatsop Behavioral Healthcare:

_____

_____

_____

_____

Purpose for Release of this Information:
**Coordination of Treatment**

Specific Information Authorized for Release:
(Initials **Required** in Spaces Below)

_____Assessment
_____Treatment Plan
_____Progress Notes
_____Medications used in treatment
_____Urinalysis Report
_____Mental Health Information
_____Alcohol and Drug Information
_____HIV/AIDS related records
_____Other: _____

This consent expires automatically as follows (check one): ☐ **1 year from date of signature** ☐ **60 days past case closure**

I can revoke this authorization at any time. I understand that the cancellation will not affect any information that was released before the revocation. I understand that information about my case is confidential and protected by state and federal law, including Code of Federal Regulations Title 42, part 2 and Title 45, parts 164 and 165. I approve the disclosure only of the named Protected Health Information. I understand what this agreement means. I am signing on my own and have not been pressured to do so. _____ (Initials)

**EXPLANATION**

Supplying your Social Security Number is voluntary and in general the refusal to supply the Social Security Number cannot be used to deny services. However, it is necessary for identifying some health insurance records.

1. **Minimum necessary information** must be requested; be specific about what is needed. Do not ask for information you do not need.
2. **Family Records**. This release covers information about the person signing the form, minor children and information about the family he/she supplied for the record. It would not cover information supplied by other adult family members unless they also sign a release.
3. **Children**. Minors can consent to mental, emotional, or chemical dependency treatment, at age 14. They may sign their own Authorization for Disclosure of PHI forms needed for such treatment.
4. The **original of this form** will be kept in the file. Copies will be sent to other agencies. The person making the photocopies will sign each copy at the bottom of the first page certifying it as a true copy. The agency receiving the authorization should reject it if there is not a signature by the person who made the copy.
5. **Redisclosure**. Information received under this authorization should not be redisclosed. Criminal penalties apply to illegal disclosure. Federal regulations (42 CFR Part 2/HIPAA) prohibit further disclosures of any PHI.
6. **Revocation**. Federal regulations do not allow us to require that the revocation be in writing; it may be revoked orally.
7. **Duration**. The authorization is valid for 1 year from date of signature or 60 days past case closure, as indicated above.
8. **Guardianship/Custody**. If the signatory is a guardian, a copy of the guardianship paper must be attached to this authorization disclosure. Similarly, if an agency has custody, and their representative signs, the custody order should be included.
9. This is a **Voluntary Form**. However, refusal to allow the Authorization for Disclosure of PHI may adversely affect eligibility determination and may prohibit the coordination of services and treatment.
10. **I affirm** that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

_____ _____
Signature of client or his/her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client