COLUMBIA COMMUNITY MENTAL HEALTH
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

SECTION A: The name of the person, or class of persons, who may authorize the requested use or disclosure:

I, _____or my authorized representative, authorize Columbia Community Mental Health to disclosure my protected health information as described in Section B below**.** I understand that:

1. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this use or disclosure.
2. I am entitled to a copy of this authorization.

SECTION B: Entities authorized to receive or use the individual's protected health information:

Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing us to disclose or who may use the protected health information described below:

_____

SECTION C: Protected health information to be used and/or disclosed:

Specifically and meaningfully describe the protected health information you are authorizing to be used or disclosed.

- ☐ Client status confirmation
- ☐ Assessment(s)
- ☐ Discharge summary
- ☐ Psychological evaluation
- ☐ Treatment plan
- ☐ History and physical
- ☐ Admission note
- ☐ Consultations
- ☐ Lab reports (examples: ECG, blood work, MRI/CT)
- ☐ Progress notes
- ☐ Physician orders
- ☐ Social/occupational history
- ☐ Medication administration record
- ☐ Psychological testing/reports
- ☐ Communications
- ☐ Information related to HIV, AIDS, Hepatitis B or Hepatitis C
- ☐ Genetic information
- ☐ Other: _____

SECTION D: Purpose of the use or disclosure:

Describe the reason for the use or disclosure of this information.

The statement "at the request of the individual" is a sufficient description of the purpose when you initiate the authorization and do not, or elect not to, provide a statement of the purpose.

_____

_____

_____

SECTION E: Signature:

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Description of Authority to Act for the Individual: _____

SECTION F: Prohibition of redisclosure:

❒ This authorization is for the use or disclosure of health information involving mental health services.

NOTICE PROHIBITING REDISCLOSURE OF PROTECTED HEALTH INFORMATION

You are prohibited from making any further disclosure of this information unless expressly permitted to do so by the written consent of the person or his/her personal representative who is authorizing its use or disclosure. (ORS 179.505(14)

❒ This authorization is for the disclosure of health information involving alcohol or drug treatment.

NOTICE PROHIBITING REDISCLOSURE OF ALCOHOL OR DRUG TREATMENT INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. 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 C.F.R. 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.

SECTION G: Expiration and revocation:

This authorization will expire (complete one):

☐ On _____/_____/_____

☐ On occurrence of the following event (which must relate to you or to the purpose of the disclosure being authorized):

_____

_____

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Privacy Officer

Telephone: (503) 438-2242

Fax: 503-397-5373

E-mail: privacyofficer@ccmh1.com

Address: PO BOX 1234, St. Helens, OR 97051