Columbia Community Mental Health (CCMH) Authorization for Columbia Community Mental Health to Use/Disclose Protected Health Information

This authorization is not required to be signed for health care services, unless the sole purpose of the health care services is for the release of medical information. CCMH will not condition treatment on providing this authorization. Refusal to sign the authorization will not affect your ability to receive health care services.

CCMH will disclose information that you have authorized and only to those entities that you have authorized.

I, ____________________________ ________________________ _____________________ ____/____/______
(Client) Last Name First Name Middle Name Date of Birth

Authorize ____ to release the following information.

For the purpose of, ____

To, _Columbia Community Mental Health (CCMH)____
Address _58646 McNulty Way___________________________________ City _St Helens_______ State __OR___ Zip _97051___

Description of information to be used/disclosed (be specific):
________ All records including: Assessment, Treatment Plan, Progress Notes and Labs
________ Other (describe): ____

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place an "X" in the applicable space next to the type of information.
________ Drug/Alcohol diagnosis, treatment or referral information
________ Mental Health
________ Intellectual/Developmental Disabilities
________ Genetic Testing
________ HIV/AIDS

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of information relating to drug/alcohol diagnosis, treatment or referral, genetic testing, mental health, HIV/AIDS and developmental disabilities.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, send a written statement to CCMH, Privacy Officer, at 58646 McNulty Way, St Helens, OR 97051 and state that you are revoking this authorization. Or, call the CCMH Privacy Officer at 503.397.5211. A revocation left on voicemail will not be enacted upon. If you are revoking a part of this authorization, please signify which parts you are revoking.

I have read this authorization and understand it. Unless revoked, this authorization will continue for ___ years from the signature date; or (time/event) ____.
Treatment after the authorization has expired, and subsequent billing and health care operations related to that treatment will require a new valid authorization. A copy of this authorization is valid as an original. I have a right to a copy of this authorization.

X ____
Signature of Individual or Personal Representative

X ____
Description of Personal Representative's Authority

X ____
Date