MULTNOMAH COUNTY
Department of County Human Services
Mental Health and Addiction Services Division (MHASD)
421 SW Oak Street, Suite 520, Portland, OR 97204
Phone: 503-988-8238 Fax: 503-988-4015

AUTHORIZATION TO EXCHANGE AND DISCLOSE HEALTH INFORMATION

Individual's Name: _____ AKA _____
Last First Middle Last First Middle
Date of Birth: _____ _____ / _____ _____ / _____ _____ _____ _____

I authorize the Mental Health and Addiction Services Division to exchange and disclose the following information with the individual/organization named below:

Initial all appropriate box(es) and give complete name and address:

___ To disclose health/medication records to:
___ To receive health/medication records from:
___ To verbally exchange health information with:

Name of Individual/Organization: _____
Contact Person/Attention: _____
Street Address: _____
City: _____ State _____ Zip _____
Phone: _____ Fax: _____

Purpose: I authorize the exchange or disclosure of the health information for the following reasons:
Continuity and Coordination of Care

Specific information to be exchanged or disclosed includes current medication records/medication list in addition to:
Behavioral health records, mental health assessment, treatment plan, medical records, progress notes, etc.

By **initialing** the spaces below, I specifically authorize the disclosure of the following health information, if such information exists:

_____ Drug/Alcohol diagnosis, treatment or referral information
_____ HIV/AIDS related records
____ Genetic testing information
____ Mental Health information

I may revoke this authorization in writing at any time to any MHASD staff. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization.

I understand that a recipient may redisclose information received unless prohibited under federal/state law or my specific consent is required. I am aware that if the recipient rediscloses my information, privacy protections provided by law may be lost.

I understand signing this authorization is not a condition to receive treatment, payment, or eligibility.

This authorization will expire in one (1) year or upon (insert date or event) _____

I understand what this authorization means and I am signing voluntarily.

Signature of Individual/Legal Guardian (circle one) | Printed Name | Date

Revocation: I no longer authorize the exchange or disclosure of my health information.

Signature of Individual/Legal Guardian (circle one) | Printed Name | Date/Time

STAFF USE ONLY
☐ Individual/legal guardian revoked verbally (phone or other): _____

MHASD Staff Member Signature/Credential | Printed Name | Date/Time