Adult Care Home Program
Aging, Disability and Veterans Services Division
421 SW Oak Street Suite 650
Portland, OR 97204
Phone: 503-988-3000

Authorization for Use and Disclosure of Individual Information

Applicant's Legal Last Name:	First Name:	Middle Initial:	Date of Birth:
Other Names Used:		Social Security Number (optional)	

By signing this form, I am authorizing the Multnomah County Adult Care Home Program to verify the information submitted in my application packet. I understand that this may include disclosure of the following information by the record holder:

Credit history & financial information	Medical/Health History
Employment history	Substantiated abuse/neglect history
Other licensing or certification records including compliance history	Child abuse/neglect and child foster home certification history

Purpose of the requested use or disclosure: The applicant named above has applied to operate, manage or work in an adult care home serving older adults and people with disabilities, adults with developmental disabilities, or adults receiving mental health and addiction services. The information received will be used to evaluate the applicant's ability to provide care for elderly or dependent individuals and to operate, manage or work in an adult care home.

APPLICANT ACKNOWLEDGEMENTS

- I was given the opportunity to ask questions about this form and what it does.
- I understand that state and federal law may protect information disclosed to Multnomah County. I understand that information will be used for the purpose of evaluating my application with Multnomah County Adult Care Home Program. I understand what this authorization means and I approve of the disclosures listed.
- I understand that I can revoke (cancel) this authorization at any time and that revocation (cancellation) will not apply to any information already disclosed. I understand that I or the person legally authorized to act on my behalf is required to submit the cancellation request in writing to the Adult Care Home Program.
- I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information, or vocational rehabilitation records without another authorization.
- I understand that the information not subject to limitation on re-disclosure as noted immediately above may be subject to re-disclosure and no longer protected under federal or state law.
- I understand that signing this authorization is a condition of licensure.
- I understand that declining to sign may prevent Multnomah County from determining licensure eligibility. Declining to sign the authorization will not affect treatment, payment, enrollment or eligibility for benefits provided to me by the record holder.

RELEASE TO	
Multnomah County Adult Care Home Program 421 SW Oak Street, Suite 650 Portland OR 97204	Telephone Number: 503-988-3000 Fax Number: 503-988-5722 Email: advsd.adult.carehomeprogram@multco.us
ATTENTION:	Email:

This authorization is valid for one year from the date of signing unless otherwise specified

_____ _____

Signature of Applicant/Individual Authorizing Release *Date*

_____

Printed Name of Applicant/Individual Authorizing Release

Complete this section only if requested by the Adult Care Home Program

AUTHORIZATION FOR RELEASE OF SPECIALLY PROTECTED INFORMATION

In addition to the above authorization, I am authorizing the record holder to disclose the following *specific* information about me effective as of the date signed below:

RELEASE FROM	
Release from record holder (*individual, employer, agency, school, medical or other provider*):	
Name of Recordholder:	Phone Number:
Address:	Email:
Specific information to be disclosed (please be as detailed as possible):	
Specially protected information: (Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand that this information will not be disclosed *unless I place initials in the box next to the information*) ☐ Mental Health _____ ☐ Alcohol/drug diagnoses, treatment, referral _____ ☐ HIV/AIDS _____	

RELEASE TO	
Multnomah County Adult Care Home Program 421 SW Oak Street, Suite 650 Portland OR 97204	Telephone Number: 503-988-3000 Fax Number: 503-988-5722 Email: advsd.adult.carehomeprogram@multco.us
ATTENTION:	Email:
Expiration date or event*:	Mutual exchange: ☐ Yes ☐ No

** This authorization is valid for one year from the date of signing unless otherwise specified*

_____ _____

Signature of Applicant/Individual Authorizing Release *Date*

_____

Printed Name of Applicant/Individual Authorizing Release