Multnomah County Health Department

PROMOTING ACCESS TO HOPE (PATH) REFERRAL FORM

****Please include attached ROIs for care coordination****

Program referral: Please check one	☐ PATH Team - pathteam@multco.us ☐ Ryan White (Individuals living with HIV) - rwabc@multco.us ☐ Gambling Services - pathteam@multco.us

Client Name:		**Date of Referral:**	
Gender Identity:		**Pronouns:**	
Race:		**Ethnicity:**	
DOB:		**Language Preference**	☐ English ☐ Spanish ☐ Other Other description:
Check all that apply:	☐ IV Use ☐ Pregnant ☐ BIPOC ☐ HIV+ ☐ LGBTQ+ ☐ Gambling ☐ Veteran ☐ Child Welfare Involvement		

Insurance Provider	Medical/OHP ID: _____ Health Plan/COO: _____		*County of coverage must be Multnomah unless Ryan White funded
Phone Number: **Email Address:**		May we contact you by: ☐ Text ☐ Email *If so, please sign attached consent	Is it okay to leave a voicemail? ☐ Yes ☐ No
Reason for referral:			
Current/ Recent Substance use:			
Any known medical or mobility needs:			
Mental Health Diagnosis:			
Current Legal Involvement:			
Housing Status:			

Hangout Area? (eg. NE, SE, North, etc.)	☐ North ☐ Northeast ☐ Inter Northeast ☐ Gresham ☐ Mid County ☐ East of 82nd ☐ Downtown Write specific location (eg. under burnside bridge, dawson park, Union station, street corners etc.):
Gambling	Does the client have a history of Gambling? ☐ Yes ☐ No
	In the last 12 months how many times have you gambled?
	Screening questions: 1. When gambling, do you find yourself becoming restless, or irritable when trying to cut down or stop gambling? ☐ Yes ☐ No 2. When gambling, do you find yourself keeping your gambling a secret from friends and family? ☐ Yes ☐ No 3. When gambling do you ever have such financial problems that you need to get help from family and friends. ☐ Yes ☐ No

PROVIDER INFORMATION OR REFERRAL SOURCE:

Agency Name:	
Contact Name:	
Phone:	
Email:	
Other Providers Involved:	

ADDITIONAL INFORMATION

Please Complete Attached ROI's for Care Coordination Purposes

EMAIL CONSENT FORM

Individuals Name: **DOB:**

RISK OF USING EMAIL

Transmitting individual information by email has a number of risks that individuals should consider. These include, but are not limited to the following risks:

- Email can be circulated, forwarded and stored electronically and on paper.
- Email can be immediately broadcast worldwide and be received by unintended recipients.
- Email senders can easily misaddress an email.
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce viruses into computer systems.
- Email can be used as evidence in court.

CONDITIONS FOR THE USE OF EMAIL

Multnomah County cannot guarantee the security and confidentiality of email communication, and will not be liable for improper use and/or disclosure of confidential information that is not caused by intentional misconduct of Multnomah County staff. Individuals must consent to the following conditions:

- **Email is not appropriate for emergency situations**.
- All emails containing protected health information to or from an individual will be printed out and made part of the individual's record.
- Multnomah County staff may receive and read your email messages.
- The individual is responsible for protecting his/her password or other means of access to email. Multnomah County is not liable for breaches of confidentiality caused by the individual or any third party.
- It is the individual's responsibility to follow-up and/or schedule an appointment if warranted.
- The individual shall avoid use of his/her employer's computer to send/receive emails to Multnomah County.
- The individual shall inform Multnomah County in writing of changes in his/her email address.
- The individual shall notify Multnomah County in writing when he/she no longer wants to receive email from Multnomah County.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information Multnomah County has provided me regarding the risks of using email. I consent to the conditions outlined above, and understand that Multnomah County may impose other conditions regarding email usage in the future.

Client/Guardian Signature	Date and Time
Client/Guardian Email Address	Client/Guardian Phone Number
BHD Staff Member Name	BHD Program

CLIENT TEXT MESSAGING CONSENT FORM

Individuals Name: **DOB:**

RISK OF USING TEXT MESSAGING

Text messaging has a number of risks that clients should consider. These include, but are not limited to the following:

- Text messages are not encrypted
- Text messages can be circulated or forwarded and may be stored
- Text messages can be received by unintended recipients
- Text message senders can easily misdirect text messages
- Back-up copies of text messages may exist even after the sender or the recipient has deleted his or her copy
- Employers have a right to inspect text messages transmitted through employer phones
- Text messages can be used as evidence in court
- Text messages may be subject to public records requests

CONDITIONS FOR THE USE OF TEXT MESSAGING

- Text messaging is not appropriate for life-threatening emergency situations
- Behavioral Health staff must not send any Protected Health Information via text messaging
- Clients must avoid sending any personal information to Multnomah County via text messaging
- Text messaging to or from a client may need to be transcribed by Behavioral Health staff into the client's services record as applicable in accordance with record retention requirements
- The client shall inform Multnomah County in writing of changes in his/her cell phone number
- The client shall notify Multnomah County in writing when he/she no longer wants to receive text messages from Multnomah County
- The client is responsible for protecting his/her cell phone or other means of access to text messaging Multnomah County is not liable for breaches of confidentiality caused by the client or any third party
- The client shall avoid use of his/her employer's cell phone to send/receive text messages to Multnomah County

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information Multnomah County has provided me regarding the risks of using text messaging. I consent to the conditions outlined above, and understand that Multnomah County may impose other conditions regarding text messaging use in the future.

Client/Guardian Signature	Date and Time
Client/Guardian Email Address	Client/Guardian Cell Phone Number
	Client/Guardian Cell Phone Carrier
BHD Staff Member Name	BHD Program

MULTNOMAH COUNTY
Health Department
Promoting Access to Hope (PATH)
Behavioral Health Division (BHD)
209 SW 4th Avenue, Suite 520, Portland, OR 97204
Phone: 503-988-9426 Fax: 503-988-4015

AUTHORIZATION FOR RELEASE OF INFORMATION

Last Name: _____ First Name: _____ Middle: _____ DOB: _____

I authorize the Behavioral Health Division to exchange and disclose the following information with the individual/organization named below: **Mark** all appropriate box(es) and give complete name and address:

☑ To exchange information with: Individual/Organization: Past, Present and Future Treatment Providers
☑ To disclose health/medication records to: _____
☑ To receive health/medication records from: Contact Person/Attention: _____
☑ To verbally exchange information with: Street Address: _____
City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

☑ **Purpose**: I authorize this exchange or disclosure for the purpose of: **Treatment, Payment, and Healthcare Operations.**

Information to be exchanged or disclosed:

☑ All of my health information
☑ All of my treatment information
☑ Other: **Substance use and Mental Health records including diagnosis, referral, treatment, and discharge information**

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

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

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

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I understand that a recipient may re-disclose information received unless prohibited under federal/state law or my specific consent is required. I am aware that if the recipient re-discloses my information, privacy protections provided by law may be lost. I understand that substance use disorder treatment records may be protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2) and cannot be re-disclosed without my written consent unless otherwise permitted or required by law. If I have named an intermediary, the intermediary may re-disclose my substance use disorder information to verified treating providers and I may request a list of re-disclosures directly from the intermediary.

I may revoke this authorization in writing at any time to any BHD staff. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization. I understand signing this authorization is not a condition to receive treatment, payment, or eligibility.

Signature of Individual/Legal Guardian	**Printed Name**	**Date**

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

Signature of Individual/Legal Guardian	Printed Name	Date/Time

STAFF USE ONLY

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

BHD Staff Member Signature/Credential	Printed Name	Date/Time

MULTNOMAH COUNTY
Health Department
Promoting Access to Hope (PATH)
Behavioral Health Division (BHD)
209 SW 4th Avenue, Suite 520, Portland, OR 97204
Phone: 503-988-9426 Fax: 503-988-4015

AUTHORIZATION FOR RELEASE OF INFORMATION

THIS ROI IS ONLY TO BE COMPLETED IF ENGAGEMENT WITH LAW ENFORCEMENT AGENCIES IS NEEDED

Last Name: _____ First Name: _____ Middle: _____ DOB: _____

I authorize the Behavioral Health Division to exchange and disclose the following information with the individual/organization named below: **Mark** all appropriate box(es) and give complete name and address:

☑ To exchange information with: Individual/Organization: _____
☑ To disclose health/medication records to: _____
☑ To receive health/medication records from: Contact Person/Attention: _____
☑ To verbally exchange information with: Street Address: _____
City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

☑ **Purpose of Disclosure/Exchange**: I authorize this exchange or disclosure for the purpose of: **Legal Proceedings**

Information to be exchanged or disclosed:

☑ All of my health information
☑ All of my treatment information
☑ Other: **Substance use and Mental Health records including diagnosis, referral, treatment, and discharge information**

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

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

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BHD Staff Member Signature/Credential	Printed Name	Date/Time