MULTNOMAH COUNTY
Health Department
Behavioral Health Division (BHD)
209 SW 4th Avenue, Suite 520, Portland, OR 97204
Phone: 503-988-8238 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:
☐ To disclose health/medication records to:
☐ To receive health/medication records from:
☐ To verbally exchange information with:

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:
☐ Care Coordination ☐ Treatment ☐ Payment ☐ Other: _____

Information to be exchanged or disclosed:
☐ All of my health information
☐ All of my treatment information
☐ Specific documents/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): _____

MHASD Staff Member Signature/Credential	Printed Name	Date/Time