Mental Health and Addictions Records
P: 503-722-6855
F: 503-722-6897
HC-BHRecords@clackamas.us

Clackamas Health Centers
Health Information Management (HIM) Dept.
2051 Kaen Rd. Suite 367
Oregon City, OR 97045

Medical and Dental Records
P: 503-650-3195
F: 503-650-3938
HC-PCRecords@clackamas.us

Authorization for the Release of Protected Health Information

(See Instructions on page 4)

Section A

Patient/Client Name:

Patient/Client Date of Birth:

Patient/Client Medical/Dental Record Number:

Patient/Client street address or P.O. Box number:_____

City: _____ State: _____ Zip: ____ Patient/Client Phone number: _____

Section B

I authorize (Who should release your information)

_____

to release the following information to (Name of recipient):

_____

Title of person I want this information to be sent to (Physician, attorney, therapist, etc.) _____

Street address, or P.O. Box number where I want the records to be sent to:_____

City: _____

State: _____ Zip: _____

Telephone number of the recipient: (___) _____

Section C

How should the records be delivered to the person listed in section B:

◯ Verbally release information
◯ Electronically send information
◯ Place information on a CD/DVD and mail to address in section B
◯ Paper copies mailed to address in section B
◯ Someone will pick up records in HIM Department
◯ Mail to above address
◯ Transmit to personal electronic medical record
◯ FAX records to (___) ___-____
◯ e-Mail or send to secure portal (Email or website address): _____

Section D

(Optional section.) Date range of the records that you would like to be sent to the recipient above (If you are in alcohol or drug treatment, your therapist will help you with determining the date range):

Treatment that occurred From: ___/___/____ To: ___/___/____

Section E

The purpose or need for the release of this information is:

◯ Treatment/coordination of care
◯ Social services/community-based services
◯ Employment support/coordination
◯ School admission
◯ Legal/Court/Corrections/Probation
◯ Disability eligibility determination (SSA disability)
◯ Billing/reimbursement by my insurance company
◯ At the request of the patient/client
◯ Other: _____

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Section F

Description of medical record/billing information to be released:

◯ Entire medical record ◯Abstract of the medical records (Minimum necessary)
◯ Office visit notes ◯ Prenatal records ◯ X-Rays ◯ Billing records ◯ Immunizations
◯ Medications ◯ Lab reports ◯ Assessments
◯ Other _____

Description of dental records to be released: ◯ Periodontal charting ◯ Dental x-rays
◯ Treatment records ◯Allergies ◯ Medications

Section G

Mental health/alcohol and drug treatment/HIV/AIDS/genetic testing information to be released:
A SPECIFIC AUTHORIZATION IS REQUIRED DUE TO ADDITIONAL STATE AND FEDERAL LAW PROTECTIONS FOR THE FOLLOWING INFORMATION. PLEASE PLACE YOUR INITIALS NEXT TO THE TREATMENT AREAS THAT YOU WOULD LIKE RELEASED, BELOW. I specifically authorize the release of the following medical records:

____ Alcohol/drug diagnosis, treatment or referral information
____ HIV/AIDS
____ Genetic testing
____ Mental health including evaluations and testing. Mental health records do not include psychotherapy notes that are maintained separately from the medical record by your therapist.

Section H

You do not have to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services, or payment for those services. If your written permission to release health information about you is needed to determine your eligibility for Oregon Health Plan or other medical program, and you do not give us permission to release your health information, you may not be able to show that you are eligible. If the reason you are receiving health care services is solely to provide information to someone else, your authorization is necessary in order for us to make that disclosure, and you will need to sign this authorization form.

I understand the information disclosed based on this authorization may be subject to re-disclosure by the person who receives these records, and may no longer be protected under Federal or State law. I understand that I may revoke this authorization in writing at any time, except doing that will not affect any records that have already been released. A revocation will not affect inspection of client/patient records necessary to validate payment by, or on behalf of governmental entities. To revoke this authorization, please send a written statement to HEALTH INFORMATION MANAGEMENT DEPARTMENT, CLACKAMAS HEALTH CENTERS, 2051 KAEN ROAD, SUITE 367, OREGON CITY, OREGON 97045, stating that you are revoking this authorization. Unless you revoke this authorization earlier, this authorization will expire one year from the date of the signature on this form unless you specify another date or event for this authorization to expire as follows:

◯ At the end of my treatment ◯ On the following date: __/__/__

◯ When the following occurs: _____

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_____ _____ ___/___/____

Signature of Client/Patient/Guardian/Legal Representative Printed Name Date

Relationship to Client/Patient _____

_____ _____ ___/___/____

Signature of Parent of Minor, or Witness, if Client/Patient makes a Mark instead of a signature

Printed name Date

TO THE RECIPIENTS OF SPECIALLY PROTECTED HEALTH INFORMATION: Any mental health, substance use disorder treatment, HIV/AIDS and Genetic testing information that has been disclosed to you is protected by Federal Confidentiality Rules (42 CRF Part 2, 45 Part 2 45 CFR Parts 160-164) and Oregon law ORS 179.505, and 192.518. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of substance use disorder treatment information is not sufficient for this purpose. Federal rules restrict the use of substance use disorder treatment records to criminally investigate or prosecute any substance use disorder patient.

**We will make every effort to have copies of records ready for pick-up within 15 days of receipt of the request. Records will be available in the Health Information Management Department, 2051 Kaen Road Suite 367, Oregon City, Oregon 97045, not your clinic location, unless you request that your records be sent to a clinic.*

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Instructions for Authorization to Disclose Protected Health Information

Section A:

The Client/patient or their legal representative must complete this section. If it is not complete, the form may be sent back to you. Complete this section with the following information:

- Client/Patient name
- Client/Patient date of birth
- Client/Patient medical record/mental health/addiction medicine case #/dental record number
- Client/Patient address
- Client/Patient phone number

Section B:

- Which person or organization do you want the information to be released from? Example: Clackamas County Health Centers
- Write the address where you want the information to be sent to e.g. ABC Medical Insurance Company, 999 SE 9th St. Portland, OR 97201

Section C: How do you want the information delivered to the person in section B? Example: CD/DVD, paper

Section D: What is the date range of the records that you are requesting? Example: medical records from October 20, 2020 to December 1, 2020. This should be filled out if you are in Substance Use Disorder treatment

Section E: What is the purpose of the disclosure of this information? Example: treatment or care coordination, disability determination

Section F: What types of information do you want released? An abstract is the minimum necessary amount of information to fulfill the reason that you are requested that records be released. Typically, the information in an abstract would be the most recent and relevant information. Example: billing records that are needed in order to have your clinic bill paid for by your insurance company.

Section G: This sensitive information is specially protected by Federal and State law. Please initial any sensitive information that you want to be released. If you don't initial anything in this section, no alcohol and drug treatment, HIV/AIDS treatment or genetic testing information will be released.

Section H: Sign and date the authorization form. If you are not the client/patient, describe your relationship with the client/patient and your legal authority to sign. Example: Legal Guardian. You will be required to provide the legal paperwork that gives you the authority to authorize the release of this information, for example legal guardianship court order.

Note: If the patient is 14 years old or older, they must sign this authorization in order to release alcohol or drug treatment records

You do not have to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services, or payment for those services. If your written permission to release health information about you is needed to determine your eligibility for Cover Oregon or other medical program, and you do not give us

permission to release your health information, you may not be able to show that you are eligible. If the reason that you are receiving health care services is solely to provide information to someone else, your authorization is necessary in order for us to make that disclosure, and you will need to sign this authorization form, unless there is a court order requiring us to release your information.

Sometimes there will be a cost-based fee in order to provide paper copies of medical and billing records, or to provide records on CD/DVDs. We will let you know what that fee is, if there is one.

Rev 7/13/2021