Health, Housing & Human Services
CLACKAMAS COUNTY

Authorization to Disclose Protected Health Information
Clackamas County Behavioral Health Division

Legal Name:	Birth Date:

Name if Different from Legal Name: _____

I authorize Clackamas County Behavioral Health (CCBH) to exchange and disclose information with:

Name of person/organization/facility: _____

Phone:_____ Fax:_____

Email:_____

Address:_____

___CCBH is REQUESTING records ___CCBH is SENDING records ___Verbal exchange only

___Mutual Exchange of records (allows information to be shared back and forth as needed)

How should the records be disclosed by CCBH (i.e. mail, email, fax):_____

Information to be exchanged and/or disclosed (check all that apply):

___Entire Health Record	___Assessments	___Progress Notes
___Treatment/Care Plans	___Medication Orders	___Lab/Diagnostic Results
___Dental Records	___Hospital Records	___Billing/Payment/Insurance
___Health Summary	___Progress Notes	___Other: _____

(*Optional section.*) Disclose records from this time period: _____ to _____
(date) (date)

By initialing the spaces below, I specifically authorize the disclosure of the following health information, if such information exists: **INITIAL EACH TO AUTHORIZE RELEASE**

(Initial) _____Substance use disorder diagnosis, treatment or referral information
(Initial) _____HIV/AIDS
(Initial) _____Genetic testing
(Initial) _____ Mental health including evaluations and testing. *Mental health records do not include psychotherapy notes.*

Continue to next page...

Purpose:
I authorize the exchange or disclosure of health information for the following reasons:

____Care Coordination ____Treatment ____Payment
____Other:_____

Acknowledgment 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 understand that if my health information is used or disclosed for treatment, payment or healthcare operations the information may be redisclosed by the recipient in compliance with the permissions in the HIPAA Privacy Rule, except for uses and disclosures for civil, criminal, administrative and legislative proceedings against me.

I may revoke this authorization in writing at any time to any CCBH 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.

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

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

Return this authorization as follows:

Email: BHBillingandRecords@clackamas.us
Fax: 503-742-5312
Mail: 11211 SE 82nd Avenue, Suite O
Happy Valley, OR 97086
Phone: 503-742-5335