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

CLACKAMAS Health Centers

Authorization to Disclose Health Information

Behavioral Health Records
P:(503)722-6855
F:(503)722-6897
HC-BHRecords@clackamas.us

Client / Patient Name _____ DOB _____ Mental Health/A&D Case # Medical/Dental Record # _____

Section A. I hereby authorize and give my permission to the providers / individuals listed below to release and/or receive a copy of my record:
(must select one box)

☐ Send records **FROM CHC** to: Name: _____
☐ Give records **TO CHC** from: Address: _____
☐ **VERBAL** exchange with CHC and: City/State/Zip: _____

DELIVERY METHOD: Phone: _____ Fax: _____
ON: ☐ CD ☐ Paper **HOW:** ☐ Mail ☐ Pick-up* on _____ ☐ Fax ☐ Email _____

**We will make every effort to have records ready for pick-up by the date specified if less than 5 working days from receipt. Records will be available at the address listed on this form, not your clinic location.*

Section B. Purpose for this disclosure: *(must select one box)*

☐ Treatment / Payment/ Operations
☐ Legal / Court / Corrections / Probation*
☐ Employment Support / Coordination
☐ Eligibility Determination (Insurance/SSA/Disability)*
☐ School Admission
☐ At the request of the individual*

**Reasonable fees may be charged to cover the cost of preparing, copying and mailing your records.*

Section C. I specifically give permission to release the following records: *(select all boxes that apply)*

☐ **Medical** ☐ **Mental Health** ☐ **Alcohol/Drug** ☐ **Dental**

Share the following documents from the record(s):			*Select dental documents to share*
☐ **ABSTRACT (minimum necessary)**	☐ Prenatal Records	☐ Lab Results	☐ Allergies
☐ Diagnoses / Problem List	☐ Treatment Plans	☐ Imaging Reports	☐ Medications
☐ Allergies	☐ Mental Health Assessments	☐ Procedure Reports	☐ Treatment Records
☐ Medications	☐ Substance Abuse Evaluations	☐ ECG / EKG	☐ Chart Notes
☐ Immunizations	☐ Psychiatric Evaluations Consult	☐ Psychiatric/Psychological Testing	☐ Periodontal Charting
☐ Vital Signs	☐ Reports	☐ Entire Record	☐ X-rays
☐ Office Visits / Progress Notes	☐ Growth Records	☐ Billing Records	

Release my records from the following dates: *(Optional)* From Treatment Date: _____ to Treatment Date: _____

Section D. Release of the following records and information **REQUIRES** specific authorization. My **INITIAL** below authorizes the voluntary release of the following treatment records:

_____Alcohol / Drug _____Mental Health _____Genetic Testing _____HIV / AIDS

Section E. I understand I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. A revocation will not affect inspection of records necessary to validate expenditures by or on behalf of government entities. To revoke this authorization, please send a written statement to HEALTH INFORMATION SERVICES at CLACKAMAS HEALTH CENTERS and state that you are revoking this authorization. Unless revoked earlier, by CHECKING one box below this consent will expire:

◯ **End of my treatment** with CHC ◯ **1 year** from the date I sign ◯ upon the **event** or **date** indicated: _____

SIGNATURE (Client, Guardian, or Person Authorized To Sign for Client) *	NAME-Please Print	RELATIONSHIP TO CLIENT	DATE

SIGNATURE (Parent of minor A&D client *or* Witness if client makes mark)	NAME-Please Print	RELATIONSHIP TO CLIENT or TITLE	DATE

If Other than Parent, must provide **PROOF OF LEGAL REPRESENTATION in the form of custody order, guardianship order, or health care power of attorney.*

SIGNIFICANT INFORMATION: Information used or disclosed under this authorization may be subject to re-disclosure by others without your permission and no longer protected under federal law. In some instances, federal and state law may protect your information from being shared if it is HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information. You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. 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, then you may not be able to show that you are eligible. **TO THE RECIPIENTS OF PROTECTED HEALTH INFORMATION:** The information disclosed to you by this authorization is protected by state law (ORS 179.505, 192.518) and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol and drug treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.

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/substance use disorder medicine case #/dental record number
- Client/Patient address
- Client/Patient phone number
- 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
- How do you want the information delivered to the person in section B? Example: CD/DVD, paper

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

Section C: 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.

- 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 D: 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 select anything in this section, no substance use disorder treatment, HIV/AIDS treatment or genetic testing information will be released.

Section E: 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 substance use disorder 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 Oregon Health Plan, or other medical programs, 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 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.

There may be a cost-based fee in order to provide paper copies of medical and billing records, or to provide records on CD/DVDs.

CLACKAMAS Health Centers

Health Information Management
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