Behavioral Health Records
P: (503) 722-6855
F: (503) 722-6897

Clackamas Health Centers
2051 Kaen Road Suite 367
Oregon City, OR 97045

Medical & Dental Records
P: (503) 650-3195
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AUTHORIZATION AND METHOD TO SHARE PROTECTED HEALTH INFORMATION WITH FAMILY OR FRIENDS INVOLVED IN MY CARE

NOTE: *This authorization does **NOT** allow for disclosing copies from the client's/patient's health record. If there is an anticipated need for copies of the client's/patient's Clackamas Health Centers record, the "Authorization to Disclose Protected Health Information" form must be completed and submitted to the reception staff.*

Client / Patient Name _____ **DOB** _____ **Case #** _____ **Record #** _____

I authorize Clackamas Health Centers to discuss/share protected health information about me with the following individual(s) who are involved in my care. This authorization will be in effect until I revoke it. Communication may take place in the manner listed below. **By initialing below**, I understand that this may include the following information:

_____A&D _____Mental Health _____HIV/AIDS _____Genetic Testing

To myself:

☐ Mail
- ☐ Permanent Address: _____
- ☐ Temporary Address: _____
  From Date: _____ To Date: _____
- ☐ Confidential Address: _____

☐ Phone
- ☐ On voicemail or answering machine at home: _____
- ☐ On voicemail or answering machine at work: _____
- ☐ On voicemail on mobile or cell phone: _____

☐ Fax _____ ☐ Email _____

☐ EHR Patient Portal: ☐ Epic MyChart

To the following family member(s) or other person(s):

1. _____ **Name** _____ **Relationship to Client/Patient** _____ **Phone #**

☐ Pick-up Prescriptions & Medications – **LIMITED TO ONE INDIVIDUAL AND PICTURE ID WILL BE REQUIRED AT TIME OF PICK UP**

2. _____ **Name** _____ **Relationship to Client/Patient** _____ **Phone #**

☐ Make, Cancel or Re-schedule Appointments ☐ Attend Appointments with me
☐ Any information about my treatment **OR** ☐ Limited to: _____

3. _____ **Name** _____ **Relationship to Client/Patient** _____ **Phone #**

☐ Make, Cancel or Re-schedule Appointments ☐ Attend Appointments with me
☐ Any information about my treatment **OR** ☐ Limited to: _____

This authorization will expire when revoked in writing by me or my authorized representative, or in the case of a minor, on the date the minor becomes an adult under state law, whichever occurs first. Submitting a new form will revoke the existing form.

I understand that the family member(s) or other(s) I have designated above could share information about me without my permission and that my protected health information would no longer be confidential. My ability to receive health care services will not be affected if I do not sign this form.

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, **PROOF OF LEGAL REPRESENTATION MUST BE PROVIDED** in the form of custody order, guardianship order, or medical power of attorney.