

Authorization to Disclose Protected Health Information Clackamas County Behavioral Health Division

Legal Name:		Birth Date:				
Name if Different from Legal Name	2:					
I authorize Clackamas County Beha information with:		exchange and discl	ose			
Name of person/organization/faci	lity:					
Phone: Fax:						
Email:						
Address:						
CCBH is REQUESTING recordsCCBH is SENDING recordsVerbal exchange onlyMutual 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 RecordTreatment/Care PlansDental RecordsHealth Summary		Lab/Diagnos Billing/Paym	Progress NotesLab/Diagnostic ResultsBilling/Payment/InsuranceOther:			
(<i>Optional section.</i>) Disclose records	to	to				
(Optional section) Disclose records	, mom time periodi	(date)	(date)			
By initialing the spaces below, I speinformation, if such information ex			=			
(Initial)Substance use di (Initial) HIV/AIDS (Initial) Genetic testing (Initial) Mental health in not include psyc	isorder diagnosis, treatr	ment or referral info	rmation			
		Continue t	o next page			

Purpose	e: ize the exchange or disc	losure of healt	h information f	or the followin	ng reasons:
	_	Treatn		Paym	_
Acknow	ledgment and Agreeme	ent:			
I unders federal/ disclose substand governing cannot be by law. I disorder directly disclose redisclose	tand that a recipient manatate law or my specific is my information, private use disorder treatments of Confidentiality of Subsect of I have named an intermation to verified from the intermediary. It is to be the treatment, payments of the treatment, payments of uses and disclosures the state of the treatment of the intermediary.	ay re-disclose in consent is requery protections posteriors may estance Use Discompositions with treating providual and erstand the compliance with compliance with	uired. I am awa provided by law be protected order Patient F sent unless oth termediary ma ders and I may hat if my health e operations the othe permissio	re that if the row may be lost. If under the fede Records (42 CFI nerwise permit by re-disclose marequest a list on information in the HIPAA	ecipient re- l understand that eral regulations R Part 2) and eted or required my substance use of re-disclosures is used or may be A Privacy Rule,
the revo	voke this authorization incation will not apply to norization. I understand nt, payment, or eligibilit	information the signing this aut	at has already	been disclosed	in response to
	nis authorization will exp nsert date or event for e				
Signat	cure of Individual/Legal (Guardian	Printed N	Jame	Date
Return	this authorization as fol	lows:			
Email:	BHBillingandRecords@	clackamas.us			
Fax:	503-742-5312				
Mail:	1211 SE 82nd Avenue,				
Phone:	Happy Valley, OR 9708 503-742-5335	ь			
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