COLUMBIA COMMUNITY MENTAL HEALTH
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

SECTION A: The name of the person, or class of persons, who may authorize the requested use or disclosure:

I, _____, DOB: _____, or my authorized representative, authorize Columbia Community Mental Health to disclose my protected health information as described in Section B below**.** I understand that:

1. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this use or disclosure.
2. I am entitled to a copy of this authorization.

SECTION B: Entity authorized to receive or use the individual's protected health information:

Name or specifically describe the person and/or organization to whom you are authorizing us to disclose or who may use the protected health information described below:

Entity name: _____

Entity address: _____ Entity Phone: _____

☐ Check this box if you authorize this entity to disclose the information selected below to Columbia Community Mental Health:

SECTION C: Protected health information to be used and/or disclosed:

Specifically and meaningfully describe the type of protected health information you are authorizing to be used or disclosed.

☐ Information related to Mental Health Records
☐ Information related to Substance Use Disorder Records
☐ Information related to HIV, AIDS, Hepatitis B or Hepatitis C Records
☐ Information related to Intellectual/Developmental Disability Records

SECTION D: Purpose of the use or disclosure:

Describe the reason for the use or disclosure of this information. If you would like to list a limit to the information shared, please describe that limit in the purpose of the use or disclosure section. Example: Limit disclosure to discussing scheduling and appointments only.

The statement "At the request of the individual" is a sufficient description of the purpose when you initiate the authorization and do not, or elect not to, provide a statement of the purpose.

_____

_____

_____

_____

SECTION E: Signature:

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Description of Authority to Act for the Individual: _____

SECTION F: Prohibition of re-disclosure:

This authorization is for the use or disclosure of health information involving mental health services.

NOTICE PROHIBITING REDISCLOSURE OF PROTECTED HEALTH INFORMATION

You are prohibited from making any further disclosure of this information unless expressly permitted to do so by the written consent of the person or his/her personal representative who is authorizing its use or disclosure. (ORS 179.505(14))

This authorization is for the disclosure of health information involving alcohol or drug treatment.

NOTICE PROHIBITING REDISCLOSURE OF ALCOHOL OR DRUG TREATMENT INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SECTION G: Expiration and revocation:

This authorization will expire on:

☐ On _____/_____/_____

*If no expiration date is entered, this authorization will expire three (3) years from the signature date.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Medical Records

Telephone: (503) 438-2166

Fax: 503-397-5373

E-mail: medicalrecords@ccmh1.com

Address: 58646 McNulty Way, St. Helens, OR 97051