Options Counseling and Family Services of Oregon, Inc
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

To Our Clients: We can help you better if we are able to work with other agencies that know you and your family. By signing this form, you authorize the individual or agency listed below and Options to exchange information about you.

Client Name: _____ DOB: _____

Options Location: Please choose a location.

Agency/Individual Name: _____

Address: _____

Phone: _____ Fax: _____

Alcohol/Drug, Mental Health and Medical records include all aspects of diagnosis, treatment, and prognosis. Documents exchanged may include but are not limited to assessments, service notes, service plans, and recommendations. Educational records include both behavioral and progress reports.

		Initials	
☐ Yes	☐ No	_____ Drug/Alcohol Treatment	☐ Other, as listed: _____
☐ Yes	☐ No	_____ HIV, Diagnosis, Treatment	_____
☐ Yes	☐ No	_____ Genetic Testing	_____
☐ Yes	☐ No	_____ Social Services	_____
☐ Yes	☐ No	_____ Mental Health Services	_____
☐ Yes	☐ No	_____ Medical/Psychiatric Treatment	_____

All documents may be exchanged, unless I specify otherwise: ☐ Yes ☐ No

Items not to be included: _____

This release will expire one year from date of signature unless I specify otherwise below

Event: _____

Information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, 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 services or reimbursement for services. The only circumstance when refusal to sign this authorization means you will not receive services is if the services are solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.
You may revoke this authorization in writing at any time. If you revoke this authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. To revoke this authorization, please send a written statement to: ATTN: Medical Record, 1255 Pearl St. Suite 102, Eugene OR 97401 AND state that you are revoking this authorization.

☐ Client ☐ Guardian
☐ Parent ☐ Legal Custody

_____ Signature

_____ Date

To those receiving information under this authorization: The information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.