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

I authorize Options Counseling & Family Services to use and disclose a copy of the specific health information described below regarding:

Name of Individual: ______________________ **DOB:** ______________

Options Location: Beaverton - 8285 SW Nimbus Ave, Ste 148; Beaverton, OR 97008 Fax: (503)352-3262

Agency/Individual Name: ______________________

Address: ______________________

Phone: ______________ Fax: ______________

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. Information used or disclosed on this authorization may be subject to redisclosure and could no longer be protected by federal and state laws on use and disclosure. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information. **Initial each documentation category you are authorizing.**

_________ Drug/Alcohol Treatment _________ HIV, Diagnosis/Treatment
_________ Genetic Testing _________ Social Services
_________ Mental Health Services _________ Medical/Psychiatric Treatment
_________ Other, as listed: ______________________

For the purpose of:
☐ Legal ☐ Care Coordination ☐ Other, as listed: ______________________

All documents may be exchanged, unless I specify otherwise: ☐ Yes ☐ No
Items not to be included: ______________________

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.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, send a written statement to: **Options Medical Records, 3500 Chad Dr. #350, Eugene OR 97408.**

I have read this authorization and I understand it. Unless revoked, this release will expire **one year** from date of signature or upon the applicable date or event, as listed: ______________________

______________________ ______________
Signature of Individual or Personal Representative **Date**

Description of personal representative's authority: ☐ Parent ☐ Legal Custodian ☐ Guardian ☐ Other, as listed: ______________

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.