

Check if one-time only release
 Check if PCP release

CBHC is REQUESTING records
 CBHC is SENDING records

Cascadia Behavioral Healthcare
AUTHORIZATION TO USE / EXCHANGE HEALTH INFORMATION
4212 SE Division St, Suite 100, Portland, OR 97206
Phone 503-238-0705, Fax 503-236-7166

Client's Name: _____
Last First Middle

Date of Birth: _____ **Home Phone:** _____

Address: _____
Address City State Zip

I authorize the following individual or agency to provide/exchange the following information with **Cascadia Behavioral Healthcare:**

Name:
Address:
Phone Number:
Fax Number:

(If records cannot be provided at no charge, do not fill request)

ONLY ITEMS INITIALED WILL AUTHORIZE the disclosure of information.

_____ (**← Initial here**) **MENTAL HEALTH** treatment or evaluation, to include information pertaining to sexual assault, child abuse and neglect, hospital records, medical records, laboratory reports and school records.

_____ (**← Initial here**) **ALCOHOL / DRUG / GAMBLING** diagnosis, treatment, and prognosis information. I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations (CFR) governing confidentiality of alcohol and drug abuse patient records. **Recipients of this information may re-disclose it only with my written consent** or as permitted by 42 CFR Part 2.

_____ (**← Initial here**) **HIV (AIDS)** diagnosis, treatment, and prognosis information

[This Box **MUST** be Completed for All Requests for Information] Check here for **VERBAL information exchange ONLY**

CLIENT: Please check "How Much" AND "What Kind/ Description" to authorize quantity / type of information to be disclosed:

- **HOW MUCH** information is to be disclosed: Last 6 mo Last 1 Yr Last 2 Yrs All Other: _____

- **WHAT KIND or DESCRIPTION** of information is to be disclosed:

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emergency Notification Information (Emergency Contact) | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment Plan | <input type="checkbox"/> Yes <input type="checkbox"/> No Assessment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Progress Notes / Reports | <input type="checkbox"/> Yes <input type="checkbox"/> No Med Orders/Med Notes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Psych Evaluation | <input type="checkbox"/> Yes <input type="checkbox"/> No Lab Work/Test Results |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Discharge Summary | <input type="checkbox"/> Yes <input type="checkbox"/> No Other: |

PURPOSE OF DISCLOSURE: I authorize Cascadia to use/exchange my health information noted above for the **purpose of evaluation, treatment planning, service coordination, monitoring, and treatment referral**. If this Authorization is to be used for additional purposes, or purposes other than those noted here, please indicate _____:

*****I understand Cascadia Behavioral Healthcare cannot guarantee information will not be disclosed if the information is released to an organization NOT SUBJECT to Federal and State laws.*****

TERM: I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. I understand that I may refuse to sign this authorization, and that refusal to sign this authorization may affect Cascadia's ability to coordinate and obtain services. Without my express revocation, **this Authorization will expire 1 year from the date of signing** or shall remain in effect for the period reasonably needed to complete the request, unless otherwise specified below:

_____ This Authorization is limited to the following time period or until the following event occurs: _____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and exchange of my health information. By my signature, I hereby, knowingly and voluntarily authorize Cascadia to use or exchange my health information in the manner described above.

Signature of Client **Date**
Note: If Client is a minor, 14 years of age or older, and is not seeking services on his/her own behalf or is otherwise unable to sign this Authorization, obtain the following signature:

Signature of Authorized Personal Representative **Date**