☐ 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

847 NE 19th Ave, Suite 100, Portland, OR 97232
Phone 503-238-0769, Fax 503-764-9228

Client's Name: ______________________________
Last First Middle

DOB: ____________________ **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:

☐**Yes** ☐**No Emergency Notification Information (Emergency Contact)**

☐Yes ☐No Treatment Plan
☐Yes ☐No Progress Notes / Reports
☐Yes ☐No Psych Evaluation
☐Yes ☐No Discharge Summary
☐Yes ☐No Assessment
☐Yes ☐No Med Orders/Med Notes
☐Yes ☐No Lab Work/Test Results
☐Yes ☐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**