CASCADIA
BEHAVIORAL HEALTHCARE
WHOLE HEALTH CARE™

☐ CBHC is REQUESTING records
☐ CBHC is SENDING records

Cascadia Behavioral Healthcare
AUTHORIZATION TO USE / EXCHANGE HEALTH INFORMATION
Central Records: 4212 SE DIVISION ST STE 100, PORTLAND OR 97206
Phone: 503-238-0705 **Fax: 503-236-7166**

Individual's Name:_____

DOB:_____ Medical Record Numbers Credible:_____; Epic: _____
Home Phone: _____

Address:_____
Address City State Zip

I authorize the following individual / 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)

Type of health information to be released: Only initialed items will be released. Please be sure to INITIAL the categories (Mental Health / HIV (AIDS) / Physical Health / Alcohol / Drug / Gambling) of records to be released AND all the subcategories that apply:

INIITAL: _____ Mental Health Records * (INITIALS REQUIRED IN ALL APPLICABLE SPACES BELOW)

_____ Entire Health Record	_____ Assessment / Evaluation	_____ Treatment Plan	_____ Service Notes	_____ Discharge Summary	_____Medication Orders
_____ Lab Test Results	_____ Billing, Payment, & Insurance	_____Hospital Records	_____Urinalysis Results	_____Health Summary	_____Residential Services
_____ Other:					

INITIAL: _____ Alcohol / Drug / Gambling Records 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. ** **(INITIALS REQUIRED IN ALL APPLICABLE SPACES BELOW)**

_____ Entire Health Record	_____ Assessment / Evaluation	_____ Treatment Plan	_____ Service Notes	_____ Discharge Summary	_____ Medication Orders
_____ Lab Test Results	_____ Billing, Payment, & Insurance	_____ Hospital Records	_____Urinalysis Results	_____Health Summary	_____ Residential Services
_____ Other:					

INITIAL: _____ HIV (AIDS) Records (INITIALS REQUIRED IN ALL APPLICABLE SPACES BELOW)

_____Entire Health Record	_____ Assessment / Evaluation	_____ Treatment Plan	_____ Service Notes	_____ Discharge Summary	_____ Medication Orders
_____ Lab Test Results	_____ Billing, Payment, & Insurance	_____Hospital Records	_____ Urinalysis Results	_____ Health Summary	_____ Residential Services
_____ Other:					

INITIAL: _____ Physical Health Records (INITIALS REQUIRED IN ALL APPLICABLE SPACES BELOW)

_____ Entire Health Record	_____ Service Notes/Progress Notes	_____ Discharge Summary	_____ Medication Orders	_____ Lab Test Results
_____ Billing, Payment, & Insurance	_____ Other:			

Purpose of Disclosure: I authorize Cascadia to use / exchange my health information noted above for the purpose of payment, evaluation, treatment planning, service coordination, monitoring, and treatment referral. If this Authorization is to be used for additional or other purposes, such as housing or legal proceeding, you must indicate this here:_____

Time period of records and health information to be disclosed:

Records for the last:	☐ 6 months	☐ 1 year	☐ 2 years	☐ All
Records for the period of time from to .				

EXPIRATION TIMEFRAME: Without my express revocation, this Authorization to Release, Receive, Use, Disclose, or Exchange Health Information will expire 1 year from the date of signature or as specified below:

☐ **Until the following date _____**

☐ **Until the following event occurs (e.g. end of treatment, 6 months after end of treatment, death):_____**

* I understand that my records are protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPPA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

** I understand that my records are protected under the Federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.

I have read and understand the terms of this Authorization to Release, Receive, Use, Disclose, or Exchange Health Information. 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 disclose my health information in the manner described on this Authorization.

_____ _____

Signature of Individual **Date**

Note: If Individual is a minor, 14 years of age or older, & is not seeking services on their own behalf or is otherwise to unable to sign this Authorization to Release, Receive, Use, Disclose, or Exchange Health Information, obtain the following signature.

_____ _____ _____

Signature of Authorized Personal Representative **Relationship to Individual** **Date**

Redisclosure of Alcohol, Drug, and Gambling Treatment Records: Information disclosed to you from records protected by Federal confidentiality rules (42 CFR 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 CFR 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.

Revoking this Authorization: You may revoke this authorization, except to the extent that Cascadia Behavioral Healthcare has taken action in reliance upon it, by mailing a written revocation statement to Cascadia's Privacy Officer at:

CASCADIA BEHAVIORAL HEALTHCARE
ATTN: FREDERICK STATEN, Ph.D.
PO BOX 8459
PORTLAND, OR 97207-8459