

☐ 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

OB:	Medical Re	ecord Numbers Cred	lible:	; Epic:	
ome Phone:	Wedled No				
ddress:					
	ldress	City		State	Zip
I authorize the follow	ving individual / agency to pro	ovide / exchange the f	following information	n with Cascadia Bel	navioral Healthcar
Name:					
Address:					
Phone Number:					
Fax Number:					
the categories (I		OS) / Physical Heal ND all the subcate	th / Alcohol / Di egories that app	rug / Gambling) ly:	of records to be
NIII AL: IVI	ental Health Records * (INITIALS REQUIRE	D IN ALL APPLIC		
Entire	Assessment /	Treatment	Service	Discharge	Medication
	Fugluation	Dlan	Motos		
Health Record	Evaluation	Plan	Notes	Summary	Orders
	Evaluation Billing, Payment, & Insurance	Plan Hospital Records	NotesUrinalysis Results	SummaryHealth Summary	
Health Record Lab Test	Billing, Payment, &	Hospital	Urinalysis	Health	Residentia
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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): 1 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 oursuant 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. Parts 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 in the manner described on this Authorization.	INITIAL: Physical	Health Records (INITI	ALS REQUIRED IN AL	L APPLICABLE SPAC	ES BELOW)
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:	Entire Health Record				Lab Test Results
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:		Other:			
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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.	[=				
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:			1 year	│	
Information will expire 1 year from the date of signature or as specified below: Until the following date	Records for the period of	time from to			
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Signature of Authorized Personal Representative Relationship to Individual Date			& is not seeking services	on their own behalf or i	_
	Signature of Authorized Pers	sonal Representative	Relationship to Individu	ıal Date	2

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