🞎 CBHC is REQUESTING records

¨ CBHC is SENDING records

**Cascadia Behavioral Healthcare**

**AUTHORIZATION TO USE / EXCHANGE HEALTH INFORMATION**

**Clinic Address: ­­­­­­­­­­­­­­\_18766 SE Stark St. Portland, OR 97233­\_\_\_**

**Phone: \_\_503-243-2236\_\_Fax: \_\_503-243-2429\_\_\_\_\_\_\_\_**

**Individual's Name:**

**DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Medical Record Numbers Credible:\_\_\_\_\_\_\_\_\_ \_\_

**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 checked items will be released. Check all which apply:**

**\_\_\_\_ Mental Health Records** \*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ] 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:  |

**\_\_\_\_\_ 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. \*\*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ] 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:  |

**\_\_\_\_\_ HIV (AIDS) Records**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ] 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:  |

**\_\_\_\_\_ Physical Health Records**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ] 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.

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**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.