AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION
DESCHUTES COUNTY HEALTH SERVICES

MRN:_____

Legal Last Name(s) of Client:	**First Name:**	**MI:**	**Date of Birth:**
Other names used by Client (if any):			

This form is used to release the client's protected health information as required by federal and state privacy laws. The authorization and signature allows Deschutes County Health Services to release the protected health information to a person or organization that the client/guardian indicates on this form.

RECORDS			
	Record Holder:	**Specific information to be disclosed:** *(include what health records are to be released and a date range if applicable)*	**Mutual Exchange:***
	Deschutes County Health Services (DCHS)		☐ **Yes** ☐ **No**
	**Mutual exchange allows information to be shared back and forth between the record holder and the recipient. Selecting "Yes" above means you approve mutual exchange.*		
	If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information. Place your **initials** to authorize: ***(INITIAL:)*** **_____ Mental Health** *(except psychotherapy notes)* ***(INITIAL:)*** **_____ HIV/AIDS** ***(INITIAL:)*** **_____ Alcohol/Drug Diagnosis, Treatment, Referral** ***(INITIAL:)*** **_____ Genetic Testing**		

RECIPIENT			
	Release to: *(List the person or organization that will receive the information. Include contact information such as fax, phone, and/or address.)*	**Purpose of release:** *(Reason for releasing the information, such as continuing care, legal, agency assisting client, etc.)*	**Expiration date or event**:**
	***This authorization is valid for one year from the date signed, unless a different expiration date is specified above.*		

ACKNOWLEDGEMNT	
	I understand that I can cancel this authorization at any time by providing a request in writing to Deschutes County Health Services (contact Medical Records for assistance). Any cancellation will not affect information that was disclosed before my cancellation notice was received by Deschutes County Health Services. I understand that information disclosed based on this authorization may be shared by the recipient and no longer protected under federal or state law. Information related to HIV/AIDS, mental health, alcohol or drug treatment, or genetic testing information may not be shared again without my authorization or as otherwise permitted by federal or state law. I understand I may refuse to sign this form and **Deschutes County cannot deny Client services if I do not sign this authorization.** I am not acting under pressure or threat. I acknowledge that I have a right to a copy of this form. I acknowledge that I have reviewed Deschutes County's written "Notice of Privacy Practices For Deschutes County." By signing this form, I authorize Deschutes County Health Services to disclose the specified confidential information.

SIGNATURE		
	Signature of Individual or Authorized Representative: X	**Date:**
	Print Name of Person Signing This Authorization:	**Relationship to Client:**

Completed forms can be sent to DCHS Medical Records at hsmedicalrecords@deschutes.org or faxed to 541-322-7567