

COOS HEALTH & WELLNESS

Behavioral Health 281 Laclair Street Coos Bay, OR 97420

Phone: Fax #: 541-266-6700 541-888-8726

AUTHORIZATION FOR RELEASE OF INFORMATION (School)

Patient's Name:			A considerate track to the
	Last	First	Middle
Home Address:			
Home Telephone:		Date of Birth:	AND BUILDING TO THE
authorization inclu olease initial) Information Information	/records about treatment or evaluate about alcohol or drug abuse treatn	tion of a Mental Health/F ment program services. EP when completed	Psychiatric nature. Mutual
RECORD HOL	.DER:		Exchange Y/N
Name of School:			
Address:			
Address:			
RECIPIENT			*Expiration
Name:	COOS HEALTH AND WELLNESS	>	
Address:	281 Laclair Street	2 7 3	
	Coos Bay, OR 97420		
treatment, payment of PURPOSE: I autoprovider to disclose n	r health care operations purposes.	my physician, treatment m of this Authorization fo	eeded by Coos Health and Wellness for mental health care, and/or health care or the following specific purpose(s):

*PROVIDE A COPY OF SIGNED AUTHORIZATION TO CLIENT.

COOS HEALTH AND WELLNESS RELEASE OF INFORMATION FORM

I understand that once Coos Health and Wellness discloses my health information to the recipient, Coos Health and Wellness cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Oregon law governing the use and disclosure of my health information. (A recipient of health records or information is generally not permitted to re-disclose the records or information without the client's authorization unless permitted under Oregon law [ORS 179.505(14)].) I understand that once Coos Health and Wellness receives my health information they will not re-disclose my health information to a third party except as required or provided by applicable federal and Oregon law governing the use and disclosure of my health information.

I understand that Coos Health and Wellness, My physician and/or medical health care provider may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Coos Health and Wellness; except, however, if my treatment at Coos Health and Wellness is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Coos Health and Wellness may refuse to treat me if I do not sign this Authorization. If my treatment is related to my participation in a research study, I understand that Coos Health and Wellness may refuse to treat me if I do not sign this Authorization.

I understand that I may at any time make a written request to Coos Health and Wellness to inspect and/or obtain a copy of my health information, and that Coos Health and Wellness will within five (5) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Coos Health and Wellness, My physician and/or health care provider (identified in this Authorization). The revocation will be effective immediately upon provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by Coos Health and Wellness, My physician and/or medical provider in reliance on this Authorization before it received my written notice of revocation.

I understand I may contact Coos Health and Wellness's Medical Records Office or Privacy Office by mail at 1975 McPherson Street Suite 2, North Bend, OR 97459, or by telephone at (541) 751-2500 for assistance relating to the terms of this Authorization.

I have read and understand the terms of questions about the use and disclosure of my her voluntarily authorize Coos Health and Wellness my health information in the manner described a	alth information. By my signature, I , My physician and/or medical prov	hereby, knowingly and		
Signature of Patient Note: If patient is a minor or is otherwis signatures:	Date unable to sign this Authorization, obtain the following			
Signature of Authorized Representative	Relationship to Client	Date		
Signature of CH&W Staff	Title	 Date		

Revision: 01-16-18
O:SHARED/FORMS/By Department/Records Room/001_CHW Record Holder

Coos Health & Wellness Pre-Appointment Form

Name:	First	0.01.01.00		1 004	•			
	FIIST	Middle		Last	e			
Last Name at Birth:		the second and a second continues as a secon	Social Security #:	Execution (control of the cut for control of the cut				
Emergency Contact:_	Commission by the Property Commission of the Com		Phone #:	Openion transport				
Are you able to get ap	pointment remii	nders through text?	□ NO □ YES	3				
Text Message #:	Name of the Street of the Association of the Street of the	and All the state of the state						
Tribal Affiliation:		. □ NO	YES If yes which tribe?	J. T.				
Ethnicity: (Check one)		☐ Non-Hispar ☐ Hispanic-ot		exican				
Primary Language:	(Check one)	☐ English ☐ Other:	☐ Spanish					
Interpreter Needed:		□ NO	☐ YES					
Race: <i>(Check one)</i> Veteran:	☐ White ☐ Asian ☐ YES	☐ American Indian ☐ Alaska Native	☐ Black/African Americ					
Totali.		•						
Marital Status: (Check one)		☐ Never Married☐ Divorced	☐ Married/living as Mar☐ Separated	rried □ Widov	wed			
Employment Status: (Check one)	☐ Student ☐ Volunteer/ot ☐ Unemployed	her I (looking for work)	☐ Homemaker☐ Retired☐ Disabled	☐ Emplo	oyed Full time oyed Part time workforce			
Education: Highest grade completed:								
Tobacco Use: NO YES Substance use in the past 90 days: NO YES (Marijuana, alcohol, etc.)								
Women Only: Are yo	ou pregnant	. NO	☐ YES					
HOUSEHOLD INCO	ME INFORMATI	ON	•					
PRIMARY SOURCE OF HOUSEHOLD INCOME (CHECK ONLY ONE):								
☐ Wa ☐ Ret ☐ Nor								
ESTIMATED GROSS MONTHLY INCOME: \$								
TOTAL NUMBER OF	PERSONS DE	PENDENT ON THIS I	NCOME:					
NUMBER OF DEPENDENTS RETWEEN 0 AND 17								