COOS HEALTH & WELLNESS

Behavioral Health
281 LaClair St.
Coos Bay, OR 97420
Phone: 541-266-6700
Fax #: 541-888-8726

# AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____

_____

Home Telephone: _____ Date of Birth: _____

**SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this authorization includes:**

***(please initial)***

_____ Information/records about treatment or evaluation of a Mental Health/Psychiatric nature.
_____ Information about alcohol or drug abuse treatment program services.
_____ Educational Records – including testing and IEP when completed
_____ Medical Records
_____ Other: _____

_____

Mutual Exchange **Y/N**

**RECORD HOLDER:**
Name: _____
Address: _____
Address: _____

*Expiration

**RECIPIENT**
Name: **COOS HEALTH AND WELLNESS**
Address: 281 LaClair Street
Coos Bay, OR 97420

***TERM:** Unless otherwise specified, authorization expires when no longer needed by Coos Health and Wellness for treatment, payment or health care operations purposes.

**PURPOSE**: I authorize Coos Health and Wellness, my physician, treatment, mental health care, and/or health care provider to disclose my health information during the term of this Authorization for the following specific purpose(s):

☒ Provision of and/or coordination of care and treatment
☐ Other: _____

_____

***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 Medical Records Office or Privacy Office by mail at 281 LaClair St, Coos Bay, OR 97420, or by telephone at (541) 266-6700 for assistance relating to the terms of this Authorization.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Coos Health and Wellness, My physician and/or medical provider to use or disclose my health information in the manner described above.

Signature of Patient _____ Date _____

Note: If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Authorized Representative _____ Relationship to Client _____ Date _____

Signature of CH&W Staff _____ Title _____ Date _____

# Coos Health & Wellness
## Pre-Appointment Form

**Name:**_____ _____ _____
First Middle Last

**Last Name at Birth:**_____ **Social Security #:** _____

**Emergency Contact:**_____ **Phone #:** _____

**Are you able to get appointment reminders through text?** ☐ NO ☐ YES

**Text Message #:** _____

Tribal Affiliation: ☐ NO ☐ YES
If yes which tribe?_____

Ethnicity: *(Check one)* ☐ Non-Hispanic ☐ Hispanic-Mexican ☐ Hispanic-other ☐ Unknown

Primary Language: *(Check one)* ☐ English ☐ Spanish ☐ Other: _____

Interpreter Needed: ☐ NO ☐ YES

Race: *(Check one)* ☐ White ☐ American Indian ☐ Black/African American ☐ Asian ☐ Alaska Native ☐ Other: _____

Veteran: ☐ NO ☐ YES

Marital Status: *(Check one)* ☐ Never Married ☐ Married/living as Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: *(Check one)* ☐ Student ☐ Homemaker ☐ Employed Full time ☐ Volunteer/other ☐ Retired ☐ Employed Part time ☐ Unemployed (looking for work) ☐ Disabled ☐ Not in workforce

Education: Highest grade completed:_____

Tobacco Use: ☐ NO ☐ YES Substance use in the past 90 days: ☐ NO ☐ YES
***(Marijuana, alcohol, etc.)***

**Women Only**: Are you pregnant ☐ NO ☐ YES

**HOUSEHOLD INCOME INFORMATION**

PRIMARY SOURCE OF HOUSEHOLD INCOME (CHECK ONLY ONE):

☐ Wages/Salary ☐ Public Assistance/Tanf
☐ Retirement/Pension/SSI ☐ Disability/SSDI
☐ None ☐ Other/Foster Care/Alimony

ESTIMATED GROSS MONTHLY INCOME: $_____

TOTAL NUMBER OF PERSONS DEPENDENT ON THIS INCOME:_____

NUMBER OF DEPENDENTS BETWEEN 0 AND 17: _____