COOS HEALTH & WELLNESS

1975 McPherson, Ste 2
North Bend, OR 97459
Phone: 541-751-2500
Fax #: 541-751-2661

Member of Western Oregon Advanced Health

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.
_____ Psychotherapy Notes created by a mental health professional.
_____ Information about HIV/AIDS related testing (including the fact that an IV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).
_____ Information about alcohol or drug abuse treatment program services.
_____ Information about sexual assault.
_____ Information about child abuse and neglect
_____ Educational Records
_____ IEP
_____ Medical Records
_____ Psych Social Testing and Results
_____ Behavioral Progress Notes
_____ Other: _____

_____

RECORD HOLDER: Mutual Exchange **Y/N**
Name: _____ _____

_____

Address: _____

_____

RECIPIENT *Expiration
Name: _____ _____

Address: _____

*__TERM:__ Unless otherwise specified, authorization expires when no lnger needed by Coos County Mental Health Department for treatment, payment or health care operations purposes.

PURPOSE: I authorize Coos County Mental Health Department, 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 COUNTY MENTAL HEALTH DEPARTMENT RELEASWE OF INFORMATION FORM

I understand that once Coos County Mental Health Department discloses my health information to the recipient, Coos County Mental Health Department 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 County Mental Health Department 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 County Mental Health Department, 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 County Mental Health Department; except, however, if my treatment at Coos County Mental Health Department is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Coos County Mental Health Department 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 County Mental Health Department 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 County Mental Health Department to inspect and/or obtain a copy of my health information, and that Coos County Mental Health Department 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 County Mental Health Department, 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 County Mental Health Department, 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 County Mental Health Department'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 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 County Mental Health Department, 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 CCMH Staff Title Date