COLUMBIA COMMUNITY MENTAL HEALTH

AUTHORIZATION OF COLUMBIA COMMUNITY MENTAL HEALTH TO USE AND DISCLOSE HEALTH INFORMATION

Client's Name:_____
Last **First** **Middle**

DOB: _____/_____/_____SS#_____-_____-_____Acct #: _____

Recipient: Name of person or class of persons to whom CCMH may disclose/receive my health information:_____

Address of Recipient or where my health information should be delivered:

_____

MY CONFIDENTIAL HEALTH INFORMATION THAT IS SUBJECT TO THIS AUTHORIZATION INCLUDES:

By initializing any of the lines below, I specifically authorize the use and/or disclosure of the type of health information indicated next to the box, if any such information is included in my medical records or other health information to be used or disclosed pursuant to this Authorization:

- ❑ _____ **Information about a Mental Health assessment**
- ❑ _____ **Mental Health progress notes, discharge summary**
- **X** _____ **Information about a Substance Abuse diagnosis**
- **X** _____ **Substance Abuse TX. plan, status report, UA results, discharge summary**
- ❑ _____ **Information about a Developmental Disability Services assessment**
- ❑ _____ **Information about sexual assault**
- ❑ _____ **Information about child abuse and neglect**
- ❑ _____ **Genetic testing information**
- ❑ _____ **Information about STD.**
- ❑ _____ **General medical records**
- ❑ _____ **Answering machine at phone # (_____)_____-_____**

X_____ Other: Incidental and direct information that is revealed during Family Group and Visitation

- ❑ _____ **Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of weather the results of such tests were positive or negative).**

TERM: This Authorization will remain in effect for one year or:

- **X** _____ **Until I revoke it in writing.**
- ❑ _____ **From the date of this Authorization until the _____ day of _____**
- ❑ _____ **Until the following event occurs: _____**
- ❑ _____ **Other: _____**

_____.

PURPOSE: I authorize CCMH to use or disclose my health information to the Recipient for the term of this Authorization for the following specific purpose(s): **To participate in family groups and allow visitation.**

***Provide a copy of signed Authorization to Client *Original in clinical file *Copy in billing file**
CCMH 4/28/18 Tab 14

COLUMBIA COMMUNITY MENTAL HEALTH

I understand that CCMH may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that once CCMH discloses my health information to the recipient in accordance with the terms and conditions of this Authorization, CCMH 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.

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 CCMH'S treatment of me.

I understand that I may at any time make a written request to CCMH to inspect and/or obtain a copy of my health information, and that CCMH will within five (5) days of receiving such written request and upon payment for the cost providing health information, 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 CCMH'S Privacy Office at the address listed below. The revocation will be effective immediately upon CCMH'S receipt of my written notice, except that the revocation will not have any effect on any action taken by CCMH in reliance on this Authorization before it received my written notice of revocation.

I understand that if this release pertains to my treatment for substance abuse, a verbal revocation will be honored.

I may contact CCMH'S Privacy Office by mail at: CCMH Privacy Office
PO Box 1234
St. Helens, Oregon 97051

(By phone: (503) 397-5211 / Fax (503) 397-5373)

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 CCMH to use or disclose my health information in the manner described above.

_____	_____
Signature of Client	Date
_____	_____
Witness signature	Date

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

_____	_____	_____
Signature of Authorized Personal Representative	Relationship to Client	Date

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