**RECORD COPY**

**Center for Family Development**
1258 High Street, Eugene, OR 97401 541-342-8437 / fax 541-342-1639

## Authorization to Use and Disclose Protected Health Information

_____ _____
(Name of individual for whom records or information is to be disclosed) (Date of Birth)

**Select One:** ☐ Exchange information with ☐ Provide information to ☐ Receive information from

**Authorized Agency or Individual Name:** _____

**Phone/Fax:** _____

### Information to be Disclosed:

All information in the areas listed below may be included if initialed, unless restricted as below.

_____ Mental health information

_____ Drug/alcohol diagnosis, treatment, or referral information

_____ HIV/AIDS information

_____ Genetic testing information

### Restrictions (optional):

Include ONLY the following information: _____

### The purpose of this disclosure is to:

☐ Coordinate services ☐ Fulfill individual's/guardian's request ☐ Other: _____

I understand that my records are protected by State Law (ORS 192.553-192.581, ORS 179.505) and Federal privacy regulations in the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 & 164. I understand that the information specified above will be disclosed based on this authorization.

For individuals involved in CFD's Recovery Program, confidentiality of this record is protected by Federal Law 42 CFR Part 2. Any information that identifies an individual as involved in the Recovery Program cannot be disclosed without written consent except in limited circumstances as specified in these regulations. Federal Law 42 CFR Part 2 prohibits unauthorized disclosure of Recovery Program records.

I understand that CFD has no control over possible re-disclosure of the information by the receiving agency or individual. I understand that CFD may not condition services, payment, enrollment in the health plan, or eligibility for benefits on whether I sign this Authorization.

I understand that this Authorization may be revoked in writing at any time, except to the extent that action has been taken prior to revoking it. Should I decide to revoke this Authorization prior to its expiration, I understand that I must do so in writing by submitting notification to my therapist or to the CFD Records Custodian. Unless revoked, this Authorization shall remain in effect until **90 (ninety) days following service conclusion**.

**Select One:** ☐ I do NOT want a copy of this Authorization ☐ I am being provided with a copy of this Authorization

**I understand that my signature below authorizes a disclosure of information and records between the above designated parties.**

_____ _____
Client Signature Date

_____ _____
Signature of Personal Representative Date

_____
Printed Name of Personal Representative

_____
Relationship to Individual

Staff Initials _____

**Definition of Personal Representative:**

**For Adults:** A person with legal authority to make healthcare decisions on behalf of the adult. Supporting documentation required.

**For Youth:** A parent, guardian, or other person acting in the place of a parent with legal authority to make healthcare decisions on behalf of the minor child. Supporting documentation may be required.