Marion County
OREGON
Health Department

Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	First name:	MI:	Date of birth:
Other names used by individual:			
◯ Prime ID / ◯ Case number / ◯ SSN:			
Legal last name of representative:	First name:		MI:

By signing this form below, I authorize the named record holder to disclose the following specific confidential information about me.*

RELEASE FROM

Release from one record holder:

Full name:	Address:
City, state and ZIP:	
Email address:	Phone number:

Specific information to be disclosed: (*Please be as detailed as possible. Requesting "all information" could delay the response.*)

Medical Records including current diagnosis list and any Developmental/Psychological/Mental Health Evaluation Reports

Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information.***)

HIV/AIDS: _____ **Mental health:** _____ **Genetic testing:** _____

Alcohol/drug diagnoses, treatment, referral:

RELEASE TO

Release to: (*Address required if mailed.*)

Full name: Marion County Health and Human Services	Address: 3180 Center St. NE Suite #3360
City, state and ZIP: Salem OR 97301	
Phone number: 503-910-9996	Email address: mblystone@co.marion.or.us
Purpose of the requested use or disclosure: Determination of Eligibility for Developmental Disability Services	
Expiration date or event*: one year from client acknowledgment signature	Mutual exchange: ◉ Yes ◯ No

**This authorization is valid for one year from the date of signing unless otherwise specified.*

CLIENT ACKNOWLEDGMENT		
• I was given the opportunity to ask questions about this form and what it does. • I understand that state and federal law protect information about services I receive from MCHD. I understand what this agreement means and I approve of the disclosures or releases listed. • I understand that I can revoke (*cancel*) this authorization at any time and revocation (*cancellation*) will not apply to any information already disclosed or released. Except for drug and alcohol information, the individual or a person legally authorized to act on behalf of the individual is required to submit the cancellation request in writing. Oral or written notification of the revocation of authorization for drug and alcohol information shall be accepted. Any request for revocation must be provided to your local Marion County program. • I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information, or vocational rehabilitation records without specific authorization. • I understand that the information not subject to limitations on re-disclosure as noted immediately above may be subject to re-disclosure and no longer protected under federal or state law. • **I am signing this authorization of my own free will.**		
Full legal signature of individual or a person legally authorized to act on behalf of the individual:		
Relationship to individual:	Phone number:	Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.		

Do not complete section below unless a true copy of the original authorization is required.

FOR AGENCY USE ONLY		
Name of staff person (*print*):	Initiating agency name/location:	Date:
Legal signature of agency staff certifying true copy:		
Initial and date if form has been copied:		

Required information for the client

To provide or pay for health services: If Marion County is acting as a **provider** of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are soley for the purpose of providing health information to someone esle and the authorization is necessary to make that disclosure. (*Examples of this would be assessments, tests or evaluations*.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS, OHA or Marion County Health Department service not acting as a health care provider

This is a voluntary form. Marion County cannot condition the provision of treatment, payment or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.