Marion County
OREGON
Health & Human Services

Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	**First name:**	MI:	Date of birth:
Other names used by individual:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification Type (Pick One): ◯ Prime ID ◯ Medical Record Number ◯ SSN	#		
Legal last name of representative:	First name:		MI:

*** By signing this form, I authorize those I name to disclose specific confidential information about me. If I answer "Yes" to the *Mutual Exchange* question below, I allow agencies I name to share information back and forth. This is so they can provide better services to me. ***

RELEASE FROM	
Release from (entity name):	
Contact person:	Phone number:
Address, City, State, and ZIP:	
Email address:	Fax number:
Specific information to be disclosed (Please be as detailed as possible): 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 type***.) **HIV/AIDS:** _____ **Mental health:** _____ **Genetic testing:** _____ **Alcohol/drug diagnoses, treatment, referral:** _____	
RELEASE TO	
Release to (entity name): Marion County Health and Human Services; IDD Services	
Contact person: Eligibility Department	Phone number: 503-588-5288
Address, City, State, and ZIP: 3180 Center St. NE Suite #3360	
Email address: IDDEligibility@co.marion.or.us	Fax number: 503-588-5290
Purpose of the requested use or disclosure: Determination of Eligibility for Intellectual and Developmental Disability Services	
Are these records being released for a court case? ◯ Yes ◉ No	
Expiration date or event*:	Mutual Exchange: ◉ Yes ◯ No

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

YOUR 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 Marion County Health & Human Services. 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.**
Signature of individual or legal representative:
Printed name: / 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 (print):	Initiating agency name/location:	Date:
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 solely for the purpose of providing health information to someone else 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 service, where MCHHS is 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 upon signing this authorization, except as described above. However, you should be given accurate information about 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.