AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

adapt
Integrated Health Care

Client/Patient	Legal Last Name	First	MI	Date of Birth
	_____	_____	_____	_____
	Other Names Used by Client/Patient _____			

I authorize **Adapt Integrated Health Care** to use and disclose my protected health information as described below.

Individual or Entity Authorized to Receive or Use the Protected Health Information:	
Name (Person or Organization): _____	Address: _____ City, State: Zip: _____ Phone: _____
Mutual Exchange: ☐ **Yes** ☐ **No** **Verbal Only:** ☐ **Verbal and May Receive Copies from the Chart:** ☐	

Protected Health Information to be Used and/or Disclosed:			
Check All That Apply:	☐ Mental Health	☐ Primary Care	☐ SUD (42 CFR Part 2 Protected Programs)

Check All That Apply:	
☐ **All Records** Related to Services Checked Above	
-OR SPECIFICALLY-	
☐ My name and contact information	☐ Laboratory Test Results
☐ My status as a client in treatment	☐ Discharge Plan
☐ Appointment Information & Attendance Reports	☐ Date of Discharge & Discharge Status
☐ Diagnosis	☐ Chart/Progress Notes
☐ Assessment	☐ Treatment Participation and Progress
☐ Medications and dosages	☐ Behaviors & Concerns
☐ Treatment Plan or Summary	☐ Recommendations & Management Strategies
☐ SUD History Summaries	☐ Lab/Path reports
☐ EKG Reports	☐ Diagnostic Testing
☐ Radiology reports	☐ Immunization Records
☐ Other (please be specific): _____	

If the information to be disclosed contain any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I mark in the applicable space next to the type of information.

☐**Drug/Alcohol Diagnosis, treatment and/or referral**	☐**Mental Health Information**	☐**HIV/AIDS Information**	☐**Genetic Testing Information**	☐**Sickle Cell Information**

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

adapt
Integrated Health Care

Purpose of the Use or Disclosure Check all that apply:	
☐ Facilitate payment and healthcare operations	☐ Care and service coordination
☐ Exchange information related to parole, probation, and/or legal status	☐ Continuity of Care
☐ Exchange information as relates to housing	☐ Conferencing and/or consultation
☐ Facilitate client transportation	☐ Facilitate Treatment
☐ Food stamp program, Oregon Health Plan enrollment, and Self-Sufficiency programs	☐ To allow a contact person in the case of medical emergency
☐ Exchange information related to client's treatment and progress	☐ Coordinate education services
☐ For myself for my records.	
Other: _____	

Expiration and Revocation
This authorization will expire (complete one):
• On Date: _____
• On occurrence of the following event: _____
*If no expiration date, event, or condition is listed, this consent form will expire **one year** from the date it is signed.
Right to Revoke: I understand that I may revoke this authorization at any time. I understand that revocation of this authorization will **not** affect any action Adapt Integrated Health Care took in reliance on this authorization before receiving my notice of revocation. Nor will it affect any information that was already disclosed.

Client Signature		
	_____ Signature	_____ Date
	_____ Printed Name of Client/Patient	Relationship to Client (check one): ☐ Patient ☐ Guardian ☐ Personal Representative Signature*
*If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must also be provided: _____		

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

adapt
Integrated Health Care

Important Information for the Client

To provide or pay for health services: If Adapt Integrated Health Care 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 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 is a Voluntary Form. Adapt Integrated Health Care 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 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.

You are entitled to a copy of this authorization.

This authorization is voluntary and is meant to confirm your directions.

Redisclosure:

For Primary Care and Mental Health Services: I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law.

For SUD Programs: This information has been disclosed ot you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **not** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Health Using This Form:

Terms Used: Mutual exchange allows information to go back and forth between Adapt Integrated health Care and the person or organization listed on the authorization.

Assistance: Whenever possible, an Adapt Integrated Health Care staff person should fill out this form with you. Be sure you understand the form before signing. Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an authorized person to sign on your behalf.

Minors: If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information, if you are age 15 or older.

Special Attention: For information about HIV/AIDS, mental health, genetic testing , or alcohol/drug abuse treatment, the authorization must clearly identify the special information that may be disclosed.