Authorization for CHS to Disclose Protected Health Information

This authorization is not required to be signed for health care services, unless the sole purpose of the health care services is for the release of medical information. CHS will not condition treatment on providing this authorization. Refusal to sign this form will not affect your ability to receive health care services.

CHS will disclose information that you have authorized and only to those entities that you have authorized.

I, _____Date of Birth_____ Hereby authorize Columbia Health Services ("CHS") to release the following to:

(name)_____(address)_____

(city)_____(state)_____(zipcode)_____

For the purposes of _____

- ☐ Marking this box means you authorize all the sending/receiving parties to exchange all the listed information below.
- ☐ All pertinent medical records. From_____ To_____
- ☐ Specific information as indicated_____

SPECIFICALLY PROTECTED INFORMATION
I understand that certain information in these records cannot be released without specific authorization because of federal and state laws. By **INITIALING**, I specifically authorize the release of the following confidential information.

- ☐ HIV test and test results and related information including high risk behavior documentation.
- ☐ Drug/Alcohol diagnosis, treatment or referral information.
- ☐ Mental Health Records _____
- ☐ Intellectual/Developmental Disabilities
- ☐ Genetic Testing

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of information relating to drug/alcohol diagnosis, treatment or referral, genetic testing, mental health, HIV/AIDS and developmental disabilities.

I hereby consent to the release of the above information obtained in the course of my health care. Further, I release CHS and its staff from all liability and all claims of any nature whatsoever pertaining to disclosure of information contained in my medical records. I understand that such information cannot be released without my specific consent.

I have read the above and fully understand its contents and have asked questions about anything that was not clear to me and am satisfied with the answers I have received. This authorization is valid for 90 days from the date below, unless revoked by me in writing at any time, except to the extent that action has already been taken. I further understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law. A copy of this authorization is valid as an original. I have a right to a copy of this authorization.

My records: **MAY** **MAY NOT** be sent by **FAX** **(PLEASE CIRCLE ONE)**

_____ _____
Signature of client or authorized agent Date

_____ _____
Relationship to client Witness

To revoke this release, send a written statement to CHS Director at PO Box 995 St. Helens, OR 97051 and state that you are revoking this authorization. If you are revoking a portion of this release, please indicate which portion.

This form is intended to comply with the requirements of 42 CFR 2.31 which restricts the disclosure of information relating to alcohol or drug abuse treatment unless authorized by the patient and with OAR
433.045 (3) & OAR 33312 270. Consent to HIV test required.