Authorization REVOKED on: _____
By Client ☐Verbally or ☐In Writing
Staff Signature:

CHD Center for Human Development, Inc.
2301 Cove Avenue La Grande, OR 97850 (541) 962-8800 Fax (541) 963-5272 TTY Dial 711

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Client's Name:_____ **DOB**: _____
First Middle Last

RECIPIENT: For the above-named individual, the Center for Human Development, Inc. (CHD) is authorized to receive and/or disclose my protected health information to/from:

Person and/or Organization	Address	Contact Numbers
		Phone: _____ Fax:

Send records to: CHD, Attn: Medical Records, 2301 Cove Avenue, La Grande, OR 97850 or fax to (541) 963-5272

INFORMATION COVERED BY THIS AUTHORIZATION: *I authorize the ENTIRE HEALTH RECORD **in the category that I have initialed,** with the understanding that it may include my assessment, treatment plan, progress notes, and other information about my history, diagnosis or treatment. (To limit disclosure, identify specific records in Specific/Other space.)*

➔**INITIAL each category to be included in authorization:**

____ Information in the entire **Mental Health** record
____ Information in the entire **Substance Abuse** record
____ Information in the entire **Public Health** record (including immunizations, breast exam, physical exam, Pap smear, lab or pathology results, prescription medications, or contraceptive mthd)
____ **HIV/AIDS** information
____ Information in the entire **Developmental Disability** record
____ **Academic** records (requests only) _____
____ **Specific/Other**:

PURPOSE: ☐Facilitate treatment ☐Facilitate payment ☐Notification of attendance and progress in treatment
☐Request of Individual ☐Other: _____

TERM: This Authorization will remain in effect for **ONE YEAR from date of signing** unless otherwise specified:
until _____, 20_____ **or** the following event occurs: _____

REFUSAL OR REVOCATION: I understand that I can refuse to sign or revoke (at any time) this Authorization for any reason and that any refusal or revocation will not affect the start, continuation or quality of CHD's treatment of me. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this use or disclosure. However, I also understand that a revocation will not have any effect on any action already taken by CHD in reliance on this Authorization. A revocation of this Authorization must be in writing to CHD (verbal revocation is permitted if records include alcohol or drug diagnosis or treatment).

RE-DISCLOSURE: ☐For use/disclosure of health information involving **developmental disability, physical or mental health services**:

NOTICE PROHIBITING REDISCLOSURE OF PROTECTED HEALTH INFORMATION: *You are prohibited from making any further disclosure of this information unless expressly permitted to do so by the written consent of the person or his/her personal representative who is authorizing its use or disclosure. (ORS 179.505(14)).*

RE-DISCLOSURE: ☐For use/disclosure of health information involving **alcohol or drug treatment**:

NOTICE PROHIBITING REDISCLOSURE OF ALCOHOL OR DRUG TREATMENT INFORMATION: *This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. 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 C.F.R. 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.*

I have read and understand the terms of this Authorization, and I have had an opportunity to ask questions about the disclosure of my health information. By signing this form I am confirming my authorization for CHD to use and/or disclose my health information in the manner described above. I understand that I am entitled to a copy of this document.

_____ _____ _____
Signature of Individual (or Authorized Personal Representative) Printed Name Date

NOTE: If Authorization is signed by a personal representative, a description of the representative's authority to act for the individual must be included: ☐Parent ☐Guardian ☐Authorized health care representative ☐Health care power of attorney ☐Other:_____

Signature of Staff Witness _____ Date _____