



AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Section A	Legal Last Name	First	MI	Date of Birth
	Other Names Used By Client	SSN		OHP ID

By signing this form, I authorize the following record holder (individual, school, employer, agency, or medical or other provider) to disclose the following specific confidential information about me:

	Release From	Specific Information to be Disclosed	Mutual Exchange: Yes / No
Section B	Valley Mental Health	Clinician Chart notes	Yes
	821 Saginaw Street South	Medication Records	Yes
	Salem, Oregon 97302	Laboratory Reports	Yes
	(503) 589-4046	Specific Records _____	

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. **I understand that this information will not be disclosed unless I place my initials in the space next to the information:**

HIV/AIDS _____ Mental Health _____ Drug/alcohol diagnosis, treatment, referral _____ Genetic Testing _____

	Release To (address required if mailed) If releasing to a team, list members	Purpose	Expiration Date or Event*
Section C	Name: _____	Coordination of Services	1 YR unless otherwise specified: _____ _____
	Address: _____		

	Phone: _____		

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects my health information. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

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. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health, and drug/alcohol diagnosis, treatment, or referral information.

Section D	Full Legal Signature of Individual -or - Authorized Personal Representative	Relationship to Client	Date
	Name of VMH Staff Person (print)	Phone Number of VMH Staff Person	Date

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

Full Legal Signature of Agency Staff Person Making Copies	This is a true copy of the original Authorization document.
Print Staff Name	



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Using This Form

1. **Terms Used: Mutual exchange:** A “yes” allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, a VMH 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.
3. **Guardianship/Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative’s authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.
4. **Cancel:** If you later want to cancel this authorization, contact the VMH staff person. You can remove a team member from the form. You may be asked to put the cancellation request in writing. Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. VMH can continue to use information obtained prior to cancellation.
5. **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.
6. **Special Attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed.

Re-Disclosure: Federal regulations (42 CFR Part 2) prohibit making any further disclosure of Alcohol and Drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.