DESCHUTES COUNTY HEALTH SERVICES - DEVELOPMENTAL DISABILITY PROGRAM
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

2577 NE Courtney Drive, Bend OR 97701 Phone: 541-322-7554 Fax: 541-330-4636

Client Name: _____ DOB: _____

Maiden and/or Other Names Used: _____

I authorize the individuals or agencies marked below to disclose to, and exchange with, Deschutes County Health Services/IDD Program, Protected Health Information (PHI) about client for the purposes of planning, coordinating, providing or monitoring services for me or my family, and for any of the following other specified purposes: _____.

☐	COPA	☒	School District
☐	BMC-Summit Medical / Mosaic	☒	Department of Human Services (DHS)
☐	St. Charles Health Services		Self-Sufficiency Program (AFS)
☐	PEDAL Clinic		Child Welfare Services
☐	Mindsights		Seniors & People with Disabilities (SPD)
☒	Other Medical Providers:		Volunteer Services
	Please list:		Vocational Rehabilitation
		☒	IDD Administrative Evaluation providers
		☐	
☒	Parent(s):	☐	
☐		☐	
☐		☐	

I understand and agree that the types of information marked below may be disclosed/exchanged:

☒DD Eligibility Statement	☒Individual Service Plans (ISPs)
☒Case Management Plan	☒Child and Family Support Plans
☒Progress notes (specify dates: _____)	☒Cognitive and Adaptive Evaluation(s)
☒Psychological testing	☐_____
☒Individual Education Plans (IEPs)	☐_____

I understand and agree that the following types of information may also be disclosed or exchanged, but ONLY if I place my initials in the space next to the information:

Psychiatric/Mental Health records: ____ Genetic testing information: ____
HIV/AIDS : _____ Drug/Alcohol diagnoses, treatment, referral: _____

ACKNOWLEDGEMNT

I understand that this authorization is valid for one year, unless otherwise specified. I understand that I can cancel this authorization at any time by providing written notice of cancellation to the above-identified record holder(s). Such cancellation will not affect any information that was already disclosed. I understand I may refuse to sign this form.

I understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected under federal or state law, EXCEPT THAT redisclosure by the recipient of information related to HIV/AIDS, mental health, alcohol or drug treatment, or genetic testing information is prohibited without my authorization unless otherwise permitted by federal or state law.

I understand that Client's personal health information is confidential and may be protected by state and federal laws, and I approve the release of Client's personal health information in accordance with this authorization. I am signing this authorization voluntarily and without pressure or coercion. I acknowledge that I have been offered a copy of this form, and that I have been provided a copy of Deschutes County's written "Privacy Practices Notice.

_____ _____
Signature Date Witness Date

Signator's relationship to Client: ☐ Client ☐ Legal Guardian* *Legal guardianship paperwork in client's file; will provide upon request".

INITIATING AGENCY

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other applicable laws. This is a

(Agency staff person)

true copy of the original authorization document _____ Date: _____

(Agency staff person)