Authorization for Disclosure, Sharing and Use of Individual Information

This form allows the referral, coordination and oversight of provider services.

____Check here to add a legal representative

Legal last name:	**First name:**	MI:	Date of birth:
Other names:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
ID type: __Case number; __JJIS number; __Prime ID; __Social Security Number; __State ID, Other_____			

When I sign this form, I authorize those I name to give specific personal information about me. If I answer "yes" to "mutual exchange," I allow agencies I name to share information back and forth. This is so they can provide better services to me.

Release TO:	
Purpose of the disclosure, sharing and use:	
Entity name: Oregon Commission for the Blind	
Specific information to be disclosed – please list:	
Date of records: __Most recent; __Last 6 months; __Last 12 months; __Last 24 months; other_____	
Contact person:	Address:
City, state and ZIP:	
Phone number:	Email address:
Fax number:	Mutual exchange: ___Yes ___No
Expiration date or event*:	
Do you request special health information to be released? __Yes __No **Specially protected information:** (*There may be additional laws for use and disclosure if there is the type of record or information listed in this box. I understand that* ***no information*** *will be disclosed* ***unless*** *I or my representative* ***initial next to the information types below.***) **HIV/AIDS: ____ Mental health: ____ Genetic testing: ____ Alcohol/drug diagnoses, treatment, referral: ____**	
Is there any specific information **not** to release? __Yes __No	

Release FROM:	
Purpose of the disclosure, sharing and use:	
Entity name:	
Date of records: __Most recent; __Last 6 months; __Last 12 months; __Last 24 months; other_____	
Contact person:	Address:
City, state and ZIP:	
Phone number:	Email address:
Fax number:	Mutual Exchange: __Yes __No

Expiration date or event*:
Is there any specific information **not** to release? __Yes __No

Your acknowledgment

- I was given the chance to ask questions about this form and what it does.
- I understand what this form means and I approve of the disclosures or releases listed.
- I understand that state and federal law protect information about services I receive from any listed:
  - » Agency » Business » Organization » Person
- This authorization is valid for one year from the date I sign it unless otherwise noted.*
- I understand my representative or I can cancel this authorization. However, information shared before I cancel cannot be undone. I can orally cancel an authorization for drug and alcohol information. All other cancellation requests must be written. I must provide any request to cancel to the agency, business, organization or person that is providing the information.
- I understand that federal or state law prohibits re-disclosure of the following, without authorization by me or my representative:
  - » Drug and alcohol diagnosis » HIV and AIDS information » Mental health
  - » Referral information » Treatment records » Vocational rehabilitation records
- I understand that information that does not have re-disclosure restrictions may be re-disclosed. Re-disclosed information may no longer be protected under federal or state law.
- I understand someone may need to contact me about this form to confirm my identity. They may also need to get more information.
- I understand that deciding not to sign this form may:
  - » Prevent agencies from deciding if I am eligible for certain programs.
  - » Prevent me from getting referrals. It may also make coordination of provider services more difficult.
  - » Affect my ability to get health services if it is necessary to share information.
  - » Keep the Oregon Health Plan (OHP) or Medicaid from paying for a service because they do not have authorization.
- **I am signing this authorization of my own free will.**

Signature:	
Printed name:	Date:

Security statement

This form may contain your personal information. If you return the form by email there is some risk it could go to someone you don't want to have the information. If you are not sure how to send a secure email, consider using regular mail or fax.

For questions or help to complete this form, please contact Oregon Commission for the Blind: 971-673-1588

* This authorization is valid for one year from the date I sign it, unless otherwise noted.