Authorization for Use and Disclosure of Individual Information

Legal last name of individual:	First name:	MI:	Date of birth:
Other names used by individual:			
○ Prime ID / ○ Case number / ○ SSN:			
Legal last name of representative:	First name:	MI:	

By signing this form below, I authorize the named record holder to disclose the following specific confidential information about me.*

RELEASE FROM	
Release from one record holder: (*Individual, school, employer, agency, medical or other provider.*)	
Full Name: OHA Health Systems Division	Address: 500 Summer Street NE, E-86
City, state and ZIP: Salem, OR 97301	
Email address: duii.info@odhsoha.oregon.gov	Phone number: (503) 945-5964
Specific information to be disclosed: Proof of substance use disorder treatment completion as required in Oregon Administrative Rule 735-070-0085.	
Specially protected information: (*Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand this information will not be disclosed unless I or my representative* ***place initials in the space next to the information***.) **HIV/AIDS:** _____ **Mental health:** _____ **Genetic testing:** _____ **Alcohol/drug diagnoses, treatment, referral:** _____	

RELEASE TO	
Release to:	
Full name: Oregon Department of Motor Vehicles	Address: 1905 Lana Avenue NE
City, state and ZIP: Salem, OR 97314	
Phone number: (503) 945-5000	Email address: N/A
Purpose of the requested use or disclosure: Provide DUII Treatment Completion Certificate	
Expiration date or event*:	Mutual exchange: ◉ Yes ○ No

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

CLIENT ACKNOWLEDGMENT		
• I was given the opportunity to ask questions about this form and what it does. • I understand that state and federal law protect information about services I receive from DHS|OHA. I understand what this agreement means and I approve of the disclosures or releases listed. • I understand that I can revoke (*cancel*) this authorization at any time and revocation (*cancellation*) will not apply to any information already disclosed or released. Except for drug and alcohol information, the individual or a person legally authorized to act on behalf of the individual is required to submit the cancellation request in writing. Oral or written notification of the revocation of authorization for drug and alcohol information shall be accepted. Any request for revocation must be provided to your local DHS or OHA program or local branch office. • I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information, or vocational rehabilitation records without specific authorization. • I understand that the information not subject to limitations on re-disclosure as noted immediately above may be subject to re-disclosure and no longer protected under federal or state law. • **I am signing this authorization of my own free will.**		
Full legal signature of individual or a person legally authorized to act on behalf of the individual:		
Relationship to individual:	Phone number:	Date:
If a person legally authorized to act on behalf of the individual signs the authorization form, evidence or documentation of authority to act on behalf of the individual should be provided.		

Do not complete section below unless a true copy of the original authorization is required.

FOR AGENCY USE ONLY		
Name of staff person (*print*):	Initiating agency name/location:	Date:
Legal signature of agency staff certifying true copy:		
Initial and date if form has been copied:		

Required information for the individual

Declining to sign may:

- Prevent DHS and OHA from determining eligibility for programs administered by DHS and OHA.
- Affect the ability of DHS and OHA to refer and coordinate services with providers.
- Affect the ability of the individual to receive services if the purpose of this form is to provide information necessary to receive health services.
- Affect payment for services if DHS or OHA is a provider of or paying for health care services under the Oregon Health Plan or Medicaid Program and DHS or OHA require the authorization to get reimbursement.