



**JACKSON  
COUNTY**  
Oregon



**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Federal and Oregon laws require a patient or authorized patient representative to give written permission for certain uses and disclosures of protected health information. Please complete this form to give this permission.

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Person or Entity Authorized to Disclose Information: 45 CFR § 164.508(c)(ii)**

(Who do you want to release the information? Please place a check mark beside each person or entity authorized to release information.)

**Agency/Person Initiating Form: Jackson County Mental Health Court**

<input type="checkbox"/> Department of Human Services: Child Welfare	<input type="checkbox"/> LaClinica
<input type="checkbox"/> Jackson County Health and Human Services	<input type="checkbox"/> Rogue Community Health (or Community Health Center)
<input type="checkbox"/> Jackson County Community Justice	<input type="checkbox"/> Community Works/Dunn House
<input type="checkbox"/> Jackson County Sheriff's Office	<input type="checkbox"/> Veterans' Administration
<input type="checkbox"/> Jackson County District Attorney's Office	<input type="checkbox"/> Medford Police Department
<input type="checkbox"/> Addictions Recovery Center	<input type="checkbox"/> State of Oregon Judicial Department
<input type="checkbox"/> Asante	<input type="checkbox"/> St. Vincent de Paul
<input type="checkbox"/> OnTrack Inc.	<input type="checkbox"/> Gospel Mission
<input type="checkbox"/> Salvation Army	<input type="checkbox"/> Providence Hospital
<input type="checkbox"/> Southern Oregon Public Defender, Inc.	<input type="checkbox"/> Conmed
<input type="checkbox"/> Los Abogados (Indigent criminal defense)	<input type="checkbox"/> Other (please specify):
<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Other (please specify):

**Information to be Used or Disclosed: 45 CFR § 164.508(c)(i)**

(What information do you want the person or entity authorized above to disclose?)

<input type="checkbox"/> Mental health assessments/evaluations, referrals and diagnoses	<input type="checkbox"/> Substance abuse assessments/evaluations and referrals
<input type="checkbox"/> Mental health treatment records	<input type="checkbox"/> Substance abuse treatment records
<input type="checkbox"/> Urinalysis/substance abuse testing results	

**Recipient of Information to be Use or Disclosed: 45 CFR § 164.508(c)(iii)**

(Who is authorized to use or receive the information authorized above to be disclosed?)

<input type="checkbox"/> Jackson County Mental Health	<input type="checkbox"/> Medford Police Department
<input type="checkbox"/> Jackson County Community Justice	<input type="checkbox"/> State of Oregon Judicial Department
<input type="checkbox"/> Jackson County Sheriff's Office	<input type="checkbox"/> Other (please specify):
<input type="checkbox"/> Jackson County District Attorney's Office	<input type="checkbox"/> Addictions Recovery Center
<input type="checkbox"/> Southern Oregon Public Defender, Inc.	<input type="checkbox"/> OnTrack Inc.
<input type="checkbox"/> Self	<input type="checkbox"/> Other (please specify):
<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Other (please specify):

**Reason for Disclosure: 45 CFR §164.508(c)(iv)**

(What may the person authorized above to receive the information do with the information?)

<input type="checkbox"/> At the request of the individual	<input type="checkbox"/> Other:
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**Disclosure of Specific Types of Information: 45 CFR §164.509(a)2); ORS 433.045.**

I understand that federal or state law may restrict the redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. Therefore, I understand and agree that these types of information **will only be disclosed** if I placed my **INITIALS** in the appropriate space next to that type of information. If I do not place my **INITIALS** next to a specific type of information, then I understand and agree that type of information **WILL NOT BE DISCLOSED**.

*Participation in Mental Health Court requires disclosure of mental health information and drug/alcohol diagnosis, treatment and referral information. If you consent to this disclosure please initial below.*

_____ HIV/AIDS information	_____ Genetic testing information
_____ Mental Health information	_____ Drug/alcohol diagnosis, treatment or referral information

**REQUIRED STATEMENTS**

1. The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal or state law (although federal or state law may restrict disclosure of the sensitive information described above; **45 CFR § 164.508(c)(2)(iii)**).
2. Refusal to sign this authorization will not adversely affect your ability to receive health care services or reimbursement for services. The consequences to the individual of a refusal to sign this authorization are that the patient’s health information may not be released as requested. **45 CFR § 164.508(c)(2)(ii)**.
3. You may **revoke** this authorization in writing at any time. If you revoke this authorization, the information described above may no longer be used or disclosed for the purposed described in this authorization. The only exception is when a covered entity has taken action in reliance on this authorization or the authorization was obtained as a condition of obtaining insurance. **45 CFR § 164.508(c)(2)(ii)**.

**To revoke this authorization, please send a written statement indicating your revocation to:**

NAME	Jackson County Mental Health Court Coordinator
ADDRESS	Justice Building
CITY, STATE, ZIP	100 S. Oakdale Avenue, Medford, OR 97501-3127
TELEPHONE	541-776-7171 ext. 215
FAX	541-776-7057

4. **THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR AFTER THE DATE IT IS SIGNED UNLESS YOU WRITE A DIFFERENT EXPIRATION DATE OR EVENT HERE: withdrawal or graduation from Mental Health Court. 45 CFR § 164.508(c)(v)**.

**I HAVE READ THIS AUTHORIZATION AND UNDERSTAND IT:**

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINTED NAME OF PATIENT:** \_\_\_\_\_

**PERSONAL REPRESENTATION SIGNATURE (if applicable):** \_\_\_\_\_

**PRINTED NAME OF PERSONAL REPRESENTATIVE (if applicable):** \_\_\_\_\_

**RELATIONSHIP OF PERSONAL REPRESENTATIVE TO PATIENT:** \_\_\_\_\_

**WITNESS SIGNATURE (required):** \_\_\_\_\_

**PRINTED NAME OF WITNESS (required):** \_\_\_\_\_

**LIMITATION ON FEES FOR COPIES**

Pursuant to ORS 192.563, a health care provider or state health plan that receives an authorization to disclose protected health information may charge:

- (1)(a) No more than \$30 for copying 10 or fewer pages of written material, no more than 50 cents per page for pages 11 through 50 and no more than 25 cents for each additional page; and
- (b) A bonus charge of \$5 if the request for records is processed and the records are mailed by first class mail to the requester within seven business days after the date of the request;
- (2) Postage costs to mail copies of protected health information or an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual; and
- (3) Actual costs of preparing an explanation or summary of protected health information, if requested by an individual or a personal representative of the individual.