AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

AMANI CENTER – Columbia County Child Abuse Assessment Program **MR#**_____

I voluntarily authorize the Amani Center to release medical and/or mental health information ***to***, and receive medical/ mental health and/or other confidential information ***from***:

Name of person, or Agency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____

Name of Patient: _____ **Patient DOB:** _____

Purpose of release: ☐ Continuity of care ☐ Other: _____

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:

Specify below by initialing appropriate item:

_____	Clinician office chart notes	_____	Dental records
_____	Transcribed hospital reports	_____	Laboratory reports
_____	Most recent five-year history	_____	Pathology reports
_____	Emergency and urgent care records	_____	Diagnostic imaging reports
_____	Photographs and VHS/DVD	_____	Billing statements
_____	Exchange information verbally	_____	Child abuse evaluation/examination reports
_____	Other_____		

_____ Please send the entire medical and/or therapy record (all information) to the above named recipient.

*The following items must be initialed to be included in the use and/or disclosure of other medical information:

_____ *HIV/AIDS test or results information and/or records
_____ *Mental health information and/or records
_____ *Genetic testing information and/or records
_____ *Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed). Describe: _____
_____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also may restrict redisclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I understand that the person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event)_____.

_____ _____
Signature of Patient's Legal Representative/Patient Date

_____ _____
Print Patient's Name or Name of Legal Representative (if applicable) Date

Please send information to Amani Center: P.O. Box 1001, Saint Helens, OR 97051
Amani center phone: 503-366-4005 **OR via Secure Fax at (503) 366-0314**