# RELEASE OF INFORMATION

**Lincoln County**
Department of Health and Human Services

➢ Complete **carefully** to avoid delay in complying with your release request.

**I, the undersigned,:** (from client requesting or releasing information)

| First Name *(Given Name)* | Last Name *(Family Name)* | Other Names Used *(if any)* |
|---|---|---|
| | | |

| Address *(Street Number and Name)* | Apt. Number | City or Town | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Date of Birth *(mm/dd/yyyy)* | MRN# | Telephone Number | Mobile Phone Number |
|---|---|---|---|
| | | | |

**Hereby authorize LINCOLN COUNTY HEALTH AND HUMAN SERVICES to:**

☐ please provide information to: ☐ please request information from:

| Name of Recipient | Contact Name |
|---|---|
| | |

| Address *(Street Number and Name)* | Apt. Number | City or Town | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| E-mail Address | Telephone Number | Fax Number |
|---|---|---|
| | | |

**By checking the boxes below, I authorize the release of the following records, if such exist:** (check all that apply)

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Laboratory & Pathology reports Diagnostic
- ☐ imaging/X-ray/EKG/EEG reports Chart
- ☐ Notes
- ☐ Emergency & Urgency care records
- ☐ Assessments & evaluations
- ☐ Crisis records
- ☐ Commitment & pre-commitment records
- ☐ Psychiatrist & Psychiatric Nurse Practitioner reports
- ☐ Educational records including behavior & progress
- ☐ Recommendations to Court and/or Parole and Probation Dept.
- ☐ Treatment Plans & Reviews
- ☐ Progress Notes & Case Management Notes
- ☐ Other (specify): _____

**For the purpose/reason of:** (check all that may apply)

- ☐ Coordination of care
- ☐ Change provider
- ☐ Legal reasons
- ☐ Moving/ Relocating
- ☐ Other (specify): _____

**For the time period of:**

- ☐ From:_____/____/____to:_____/____/_____
- ☐ All records
- ☐ Last_____Years
- ☐ Last_____Months

**IMPORTANT!**

If the information to be disclosed contains any of the records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I **place my initials** in the applicable space next to the type of information.

- _____ **HIV/AIDS information**
- _____ **Genetic Testing information**
- _____ **Mental Health information**
- _____ **Drug/Alcohol diagnosis, treatment, or referral information**

This permission is good for **365 days** from date of signature, until revoked, or until (specify date that is not over a year from the date of signature)_____/____/____or Event:_____

**I have read this authorization and the explanation on the reverse side and I understand it.**

_____
Signature of Client or Legal Personal Representative

____ / ____ / ____
Date

_____
Print Name

_____
Relationship to Client

_____
Received By: (Print LCHHS Employee Name)

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Department of Health and Human Services

EXPLANATION

• You do not need to sign this authorization. Refusal to sign the authorization will not affect your ability to receive health care services or payment for services. The only circumstance when refusal to sign means you 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.

• You may cancel this authorization to use and disclose your information in writing at any time. If you cancel your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To cancel this authorization, you must send a written statement stating that you are revoking this authorization, addressed to the attention of Receptionist, Lincoln County Health and Human Services at the address where you receive services and state that you are revoking this authorization. You may also cancel this authorization by appearing at the office where you receive services and writing REVOKED across the face of the authorization, the date, and your signature.

• Federal or state law may restrict redisclosure of HIV/AIDS, mental health, genetic testing, and drug/alcohol information. However, the information that you have authorized to be disclosed may be redisclosed by the person/agency receiving your protected health information and no longer be protected under federal law.

• Lincoln County Health & Human Services is entitled to request and receive reasonable fees for providing such photocopies of your health records as may be requested as a condition before their release.

• You will be given a copy of this Authorization to Disclose Information after signing.

**Redisclosure:** Federal regulations (42 CFR part 2) prohibit making any further disclosure of alcohol and drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.

**For People Who Cannot Write**

I understand this form and am completing it voluntarily. I cannot write. I am placing my mark by my name to sign this form.

| MY MARK: | Full Name of Client: | Date: / / |
|---|---|---|
| Witness #1: | Address: | Date: ____ / ____ / ____ |
| Witness #2: | Address: | Date: ____ / ____ / ____ |

**For People Who Cannot Read**

I have read the form to the client. He/She understands it and signed it voluntarily.

| Witness Name: | Signature: | Date: ____ / ____ / ____ |
|---|---|---|

**Return records to:**

☐ Newport Clinic
1010 SW Coast Hwy, Ste 203
Newport, OR 97365
Phone (541) 265-4947
Fax (541) 574-7670

☐ Lincoln City Clinic
4422 NE Devils Lake Blvd, Ste
2 Lincoln City, OR 97367
Phone (541) 265-4947
Fax (541) 994-0261

☐ Taft SBHC
3780 SE Spyglass Ridge Rd
Lincoln City, OR 97367
Phone (541) 265-0474
Fax (541) 557-1643

☐ Toledo SBHC
1800 NE Sturdevant Rd
Toledo, OR 97391
Phone (541) 265-0473
Fax (541) 336-7658

☐ Newport SBHC
322 NE Eads St.
Newport, OR 97365
Phone (541) 265-0472
Fax (541) 265-8628

☐ Waldport SBHC
3000 Crestline Dr.
Waldport, OR 97394
Phone (541) 265-0471
Fax (541) 563-7612

☐ Newport Nye Public Health
36 SW Nye St
Newport, OR 97365
Phone (541) 265-4112
Fax (541) 265-4194

☐ Newport Nye Behav. Health
36 SW Nye St
Newport, OR 97365
Phone (541) 265-4179
Fax (541) 265-4194

☐ Newport Lee Behav. Health
51 SW Lee St
Newport, OR 97365
Phone (541) 574-5960
Fax (541) 265-0601

☐ Lincoln City Behav. Health
442 NE Devils Lake Blvd
Lincoln City, OR 97367
Phone (541) 265-4196
Fax (541) 994-1882

☐ Maternity Case Mngmt
36 SW Nye St
Newport, OR 97365
Phone (541) 265-4113
Fax (541) 265-0457

☐ Developmental Disabilities
36 SW Nye St
Newport, OR 97365
Phone (541) 265-6611 ext.3286
Fax (541) 265-0603

☐ Other: _____

Completed by: