COLUMBIA COUNTY
Deflection Program

ST. HELENS, OR 97051
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Release of Information

By reading this document and signing I agree to the following terms:

1. Records

With this document, I authorize receipt and disclosure of the following protected healthcare information including:

☒ Name and contact information

☒ Demographic data, dates of medical events, diagnoses, and level of care recommendations

2. Authorized Organizations

The following organizations have been authorized to receive or disclose this client's protected healthcare information to facilitate completion of Deflection.

☒ Columbia County Deflection program

3. Purpose

The client has agreed to this authorization for the following purpose(s):

☒ Deflection Program Completion and care coordination between deflection team and community partners.

I can cancel this at any time, but I understand the cancellation will not affect any information that was already released before the cancellation. I will be asked to cancel my permission in writing. I understand that my mental health and/or alcohol/drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol/Drug Abuse Patient Records, 42 CFR, Pt. 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnoses, testing, and/or treatments for communicable diseases, including sexually transmitted, mental health services and alcohol/drug services. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment. Unauthorized re-disclosure by recipient is prohibited but may be a potential risk. I understand that I do not have to sign this authorization.

Participant:_____ Date: _____