

Empowerment Initiatives Inc.

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Portland, OR 97232

Phone: 503-249-1413

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH
INFORMATION**

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(Date)
digits of SS#)

(Customer Name)

(DOB)

(Last 4

Section A. I hereby authorize and give my permission to the providers / individuals listed below to release and/or receive a copy of my record:

To send records **FROM** Empowerment Initiatives Inc. to:

To give records **TO** Empowerment Initiatives Inc. from:

Name

Address

City/State/

ZIP

Phone _____ FAX

I give permission to those listed above to share and discuss my records with one another.

I give permission to those listed above to fax my records.

I give permission to release my records from the following dates:

Start Date _____ End

Date _____

Section B. Purpose for this disclosure (check all that apply):

Goal Planning

Eligibility Determination

Legal / Court / Corrections / Probation

At the request of the client

Other (specify):

Signature of Customer

Date

Signature of Parent or Legal Representative*

Date

*If Other than Parent, **PROOF OF LEGAL REPRESENTATION MUST BE PROVIDED** in the form of a custody order, guardianship order, or medical power of attorney.

SIGNIFICANT INFORMATION: Information used or disclosed under this authorization may be subject to re-disclosure by others without your permission. In some instances, federal and state law may protect your information from being shared by others without your permission. In some instances, federal and state law may protect your information from being shared if it is HIV/AIDS information, genetic information, or drug/alcohol diagnosis, treatment, or referral information.

If your written permission to release health information about you is needed to determine your eligibility for the Oregon Health Plan or other medical program, and you do not give us permission to release your health information, then you may not be able to show that you are eligible. If another health care provider has asked us to provide a health care service to you, such as a test or evaluation, and you do not give us your written permission to release your information to them, then we may not provide you with that health service.

TO THE RECIPIENTS OF PROTECTED HEALTH INFORMATION: The information disclosed to you by this authorization is protected by state law (ORS 179.505, 192.525) and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol and drug treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorization to Disclose PHI (revised 03/29/04) adapted from Clackamas County Release of Information