Columbia Community Mental Health (CCMH) Authorization for Columbia Community Mental Health to Disclose Protected Health Information for Individuals Receiving Alcohol and Drug Treatment

This signed authorization will permit CCMH to treat you. Refusal to sign the authorization will affect your ability to receive health care services.

CCMH will disclose information that you have authorized as required and only the minimum necessary to meet the need. Authorizing multiple entities doesn't mean all the entities will receive all of your information. Only those entities that need the information to facilitate payment and health care operations for your services at CCMH will receive your information.

I, ____________________________	________________________	______________________	____/____/______
(Client) Last Name	First Name	Middle Name	Date of Birth

Authorize CCMH to release the following information.

☐ **For Payment: To**, Care Oregon; Columbia Pacific Coordinated Care Organization (CPCCO); Greater Oregon Behavioral Health (GOBHI); Division of Medical Assistance Programs (DMAP); and Performance Health Technology **And To**, Addictions and Mental Health Division (AMH); Care Oregon; (CPCCO); (GOBHI); or other payor: ____________________ ____(DMAP) and (phtech) for **Health Care Operations.**

☐ **Other: To** ____

For the purpose of: ____

Description of (A/D Records) to be disclosed:

________ All necessary records including: Assessment, Treatment Plan, Progress and Therapy Notes and Labs

◯ Assessments ◯ Service Plan ◯ Progress Notes ◯ Therapy Notes ◯ Labs

________ Other (describe): ____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

You may revoke this authorization at any time. If you revoke 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.

I have read this authorization and understand it. Unless revoked, this authorization will continue for 1 year from the signature date; or (time/event): ____.
Treatment after the authorization has expired, and subsequent billing and health care operations related to that treatment will require a new valid authorization. A copy of this authorization is valid as an original. I have a right to a copy of this authorization.

X ____
Signature of Individual or Personal Representative

X ____
Description of Personal Representative's Authority

X ____
Date

REVOCATION:

Date:________________________________

Reason: ______________________________

____