

Columbia Community Mental Health (CCMH) Authorization for Columbia Community Mental Health to Use/Disclose FERPA Personally Identifiable Information

This authorization is not required to be signed for health care services, unless the sole purpose of the health care services is for the release of your education records. CCMH will not condition treatment on providing this authorization. Refusal to sign the authorization will not affect your ability to receive health care services.

The Family Educational Rights and Privacy Act (FERPA) protects the privacy of your education records. Education records are: (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the agency or institution. Records kept on services to students under the Individuals with Disabilities Education Act (IDEA) are education records.

CCMH will disclose information that you have authorized and only to those entities that you have authorized.

I, _____ /_____/_____
(Client) Last Name First Name Middle Name Date of Birth

Authorize _____ to release the following information.

For the purpose of, _____

To, Columbia Community Mental Health (CCMH) _____
Address 58646 McNulty Way _____ City St Helens _____ State OR _____ Zip 97051 _____

Description of information to be used/disclosed (be specific):

_____ All records including: Assessments, Evaluations, IEP, 504, Transcript
_____ Other (describe): _____

If the information to be used/disclosed contains any of the types of 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 used or disclosed if I place an "X" in the applicable space next to the type of information.

_____ Drug/Alcohol diagnosis, treatment or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of information relating to drug/alcohol diagnosis, treatment or referral.

You may revoke this authorization in writing 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. To revoke this authorization, send a written statement to CCMH, Privacy Officer, at 58646 McNulty Way, St Helens, OR 97051 and state that you are revoking this authorization. Or, call the CCMH Privacy Officer at 503.397.5211. A revocation left on voicemail will not be enacted upon. If you are revoking a part of this authorization, please signify which parts you are revoking.

I have read this authorization and understand it. Unless revoked, this authorization will continue for _____ years 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