Comagine Health

650 NE Holladay St., Suite 1700
Portland, OR 97232
comagine.org/OBHSP

Consent for Release of Information and Participation in the Oregon Behavioral Health Support Program

Member name:

Member DOB:

Insurance ID / Medicaid ID:

Consent and authorization to release information between Comagine Health and Providers of health care services

- I consent to case management services. I authorize the release to and use by Comagine Health or any designee acting on Comagine Health's behalf, of any medical, personal and employment related information for myself.
- I understand this information may be released by my attending physician or other healthcare professionals who have treated me. I understand Comagine Health may release this information to my attending physician or other health care professionals. This information may be used to assist with the case management functions of face-to-face needs assessment, person-centered service planning, follow up and support.
- I understand this information specifically may include details relating to alcohol or drug treatment, mental health treatment, communicable disease such as hepatitis, HIV, or any other medical condition or treatment. Please see **pages 3 and 4** for more information about this.
- I fully understand that the intent of this authorization is to secure information solely for the purposes of functional needs assessment and person-centered service plan development. I understand that Comagine Health will release only information necessary to arrange healthcare and/or social services.
- This authorization will remain in effect for **one year from the date noted below**, while I am receiving case management services. I understand that I may withdraw this consent in writing at any time except to the extent that action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand I have the right to receive a copy of this authorization if I so request. A signed copy of this authorization shall be as valid as the original. **If signer is other than individual, documentation of status as legal representative must be attached.**

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Member signature:____**Date** ___________________

My printed name: ____

Member representative:____**Date** ___________________

Representative's printed name: ____

If anyone signs for the member, please provide a copy of Power of Attorney or other legal document giving that permission.

Please see the next page for disclose of protected health information.

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Authorization for Disclosure of Protected Health Information (PHI)

Information about you and your health, called Protected Health Information (or "PHI"), is sensitive. Organizations, including Comagine Health, may not use this PHI or disclose it to anyone unless you say it's OK in writing. This form gives your consent to use and disclose your PHI. You *must* fill out everything marked with a star (*) for this form to be valid.

*My name (please print member's name): ____

*My date of birth: ____

I give consent to Comagine Health to use my PHI and disclose it to:	*Individual or organization: ____ Mailing address: ____ City, State, ZIP: ____ Phone number: ____ Relationship to member: ____

I am asking for my PHI to be used or disclosed because (please list reasons):

____

____

***My PHI to be disclosed includes:** All of it, or, only the items I've checked below:

Prior authorizations

Claims

Benefits

Health plan records

Billing records

Medications

I want Comagine Health to limit PHI disclosure to dates or events that I specify below:

Dates from:____________________to: ____________________

Event:____

(for example, if you went to the hospital in April 2019)

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Other information that I authorize to be disclosed: The three kinds of PHI listed below are protected by other laws. It is OK for Comagine Health to disclose this PHI only if I've initialed the space beside it on this form. **If I haven't initialed it here, Comagine Health may not disclose it.**

Initials	Type of PHI
	Anything about an HIV/AIDS test, including whether I've taken one, the results of a test and other records about it
	Any of my mental health information (excluding psychotherapy notes)
	Any information about drug or alcohol diagnoses, treatment or referrals. I also understand that federal law says no one who gets drug or alcohol information from Comagine Health can disclose it to anyone else unless I also give my written authorization to them.

***Member's signature:**____**Date** ___________________

(If anyone signs for the member, please provide a copy of Power of Attorney or other legal document giving that permission.)

My printed name: ____

Member representative:____**Date** ___________________

Representative's printed name: ____

If anyone signs for the member, please provide a copy of Power of Attorney or other legal document giving that permission.