

Oregon Behavioral Health Support Program

Consent and Release of Information

After carefully reading over the consent form, please enter the consumer/member's legal first and last name, date of birth and Medicaid ID number (If applicable)

Please write legibly if completing by hand



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.**

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.

Consumer/member signature is required if there is no representative

Legal representative signature is required (if applicable) and must be sent with supporting documentation (i.e., Power of Attorney, Legal Guardianship)

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 | Health plan records |
| Claims | Billing records |
| Benefits | 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)

Consumer's
Legal first and
last name



This form is optional. If you would like to have any Protected Health Information (PHI) shared with another agency, individual, or family member, please complete this form.

Please mark what PHI you would like to disclose to the person or organization listed above.



If you want Comagine Health to only disclose information for specific dates or event, please indicate those dates here.

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.

Initial for Comagine Health to share specific types of PHI



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.

Consumer or Consumer/ member representative signature is required if form is completed



***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.

Save as

Print

Clear form

**Once the form is complete, please
submit by email, fax, or mail.**

Email: ORBHSupport@comagine.org

Fax: 877-575-8309

Mail: 650 NE Holladay St. Suite 1700, Portland, OR 97232