DHS Oregon Department of Human Services

Authorization for Use and Disclosure of Information

Oregon Health Authority

s form is available in alternative formats including Braille, large print, computer disk and oral presentation.

Legal last name of client/applicant:	First:	MI:	Date of birth:
Esteban	Pedro		8/22/05
Other names used by client/applicant:			Case ID number:
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By signing this form, I authorize the following record holder to disclose the following specific confidential information about me:

Section A

Release from one record holder: *(individual, school, employer, agency, medical or other provider)*	**Specific information to be disclosed:**	**Mutual exchange: Yes/No**
DHS Medicaid Web Portal	OHP Managed Care Plan	YES
	Dental Exam Date	

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

HIV/AIDS: _____ **Mental health:** _____ **Genetic testing:** _____

Alcohol/drug diagnoses, treatment, referral:

Section B

Release to: *(address required if mailed)* **If releasing to a team, list members.**	**Purpose:**	**Expiration date or event*:**
Umatilla-Morrow Head Start	Assist in determining Dental Home	

***This authorization is valid for one year from the date of signing unless otherwise specified.**

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, mental health and drug/alcohol diagnosis, treatment, vocational rehabilitation records or referral information without specific authorization.

Section C

Full legal signature of individual or authorized personal representative:	**Relationship to client:**	**Date:**
Juanita Esteban	parent	7/15/09
Name of staff person *(print)*:	**Initiating agency name/location:**	**Date:**
Janet Peck	UMCHS	7/15/09
Full legal signature of agency staff person making copies:	**This is a true copy of the original authorization document.**	
Print staff person name:		