

# Healthy Families Oregon Authorization to Release Information

I, \_\_\_\_\_, request that the following information about  
(Name)

myself and/or my child(ren): \_\_\_\_\_  
(Name of Child) (Name of Child)

be shared between \_\_\_\_\_ (Healthy Families Oregon staff name)

and: \_\_\_\_\_ (Agency and/or Individual)

**Specific information to be released:**

\_\_\_\_\_

**For the specific purpose of:**

\_\_\_\_\_

***If*** you agree to release any of the following specific health related information, please check and initial below:

- YES** \_\_\_\_\_ physical health diagnoses, treatment, care plans and/or prognosis  
(Initial)
- YES** \_\_\_\_\_ mental health  
(Initial)
- YES** \_\_\_\_\_ alcohol/drug use or treatment  
(Initial)
- YES** \_\_\_\_\_ HIV/AIDS  
(Initial)

Date Release Begins \_\_\_\_/\_\_\_\_/\_\_\_\_

Date Release Ends \_\_\_\_/\_\_\_\_/\_\_\_\_  
(not to exceed one year)

***I understand that I may cancel this release at any time. I understand that the cancellation will not affect any information that was already released before cancellation. I understand that information about myself / my children / my family is confidential and protected by state and federal law. I approve the release of this information. I am signing on my own and have not been pressured to do so.***

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

***If for any reason you wish to discontinue the exchange of information between the parties listed above:***

Date Release Withdrawn: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: \_\_\_\_\_