Kolpia Counseling Services, a program of Options for Southern Oregon
611 Siskiyou Blvd. Ste 8 Ashland, OR 97520 P: (541)482-1718 F: (541)482-0964
836 E Main St. Ste 6 Medford, OR 97504 P: (541)500-8023 F: (541)500-8065

AUTHORIZATION TO USE, DISCLOSE AND RELEASE PROTECTED HEALTH INFORMATION:

I authorize Options to use and disclose a copy of the specific health information described below regarding:

Client Name:_____ DOB: _____

Patient Representative Name:_____ Phone: _____

Name of Recipient(s): Jackson County Community Justice

Recipient's Address: 1101 W Main Street, Ste 101

City: Medford State: Oregon Zip: 97501

Phone: 541-774-4900 Fax: 541-770-9484

I understand and agree that the information below will be disclosed **only** if I place **my initials** in the applicable spaces next to the type of information:

_____ HIV/AIDS testing/treatment _____ Mental Health diagnosis, treatment

_____Genetic Testing

_____Drug and Alcohol diagnosis, treatment (42 CFR Part 2 prohibits unauthorized disclosure of these records)

Purpose for disclosure : ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

☐ Other_____

Date ranges to be released: _____ ☐ All Dates

Specific Information to be released:

☐ Assessments	☐ Provider Notes (Psychiatrist, Nurse Practitioner)
☐ Access Screen(s)	☐ Medical Records
☐ Treatment Plan/Service Plan	☐ Psychiatric Evaluation
☐ Progress Notes/Service Notes	☐ Crisis
☐ Medication orders/Logs	☐ Verbal Communication
☐ Lab/Radiology Reports	

☐ Other: (Please list)

TERMS: This Authorization will remain in effect until I am discharged from services provided by Options for Southern Oregon or until I revoke this authorization in writing, or I list a date I would like it to end. Optional termination date: _____

Client Acknowledgments:

- I was given the opportunity to ask questions about this form and what it does.
- I understand that state and federal law protect information about services I receive from Options. I understand what this agreement means and I approve of the disclosures or releases listed.
- I understand that I can revoke (cancel) this authorization at any time and revocation (cancellation) will not apply to any information already disclosed or released. The individual or a person legally authorized to act on behalf of the individual is required to submit the cancellation request to Options in writing.
- I understand that this release will remain good unless I revoke it or I end treatment. When I revoke the release it will be affective now, however it does not affect any records Options already released.
- I understand that once Options discloses my health information to the recipient(s), Options cannot guarantee that the recipient(s) will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and Oregon law governing the use of my health information.
- I understand that the information not subject to limitations on re-disclosure as noted immediately above may be subject to re-disclosure and no longer protected under federal or state law.
- In addition to releasing information to the listed recipient, unless indicated otherwise, this authorization allows Options to also obtain private health information from this person or organization in order to provide treatment and treatment-related services to the patient.
- I am signing this authorization of my own free will.

I have read and understand the nature of this release. My signature indicates I agree with this authorization to release.
Signature of client: _____ Date: _____
Printed name: _____

Signature of Authorized Representative _____ Date: _____
Relationship to client: _____
Printed Name: _____

STAFF USE ONLY:
Beca ID#_____ Printed Name of Options staff: _____
Signature: _____