CODA™ health - recovery - community

1-855-SEE-CODA (733-2632)

AUTHORIZATION for RELEASE OF INFORMATION

I, ______________________________ , whose birth date is ______________ , do consent to the use or disclosure of the above named individual's treatment information as described below. The following individuals or organizations are authorized to make the disclosure.

SELECT ONE OR MORE: RELEASE ONLY RECEIVE ONLY RELEASE & RECEIVE

ORG/ID: :	FAX:
ADDRESS:	PHONE:
CITY, STATE, ZIP:	EMAIL:

THE INFORMATION TO BE RECEIVED AND/OR RELEASED IS AS FOLLOWS:

Check all records to be received and/or released:

General:
- Assessment & Diagnosis
- Treatment Plan
- Progress in Treatment
- Presence in Treatment
- Discharge Summary

Test Results & Medications:
- Current Medications
- Medication History
- Lab Results
- Urinalysis & Toxicology Results

Other:
- Billing & Financial Information
- Emergency Interventions
- ______________________

I understand that my treatment record may contain the following information, I acknowledge that this information may be released:
Acquired Immunodeficiency Syndrome (AIDS) or HIV ; Behavioral Health Services ; Mental Health Services

PURPOSE FOR THE USE AND DISCLOSURE OF THE ABOVE RECORDS IS AS FOLLOWS:

I authorize use and disclosure for the following purposes only:

Legal Proceedings: If the purpose of the disclosure is for legal proceedings, I agree to the use and disclosure of my substance use disorder treatment records to be used in the criminal, civil, legislative, or administrative proceedings identified below. **If this box is checked, no other purpose may be listed below.** Case No./Investigation No (if known).______________________________________.

At the request of patient

Other ____.

I understand that my substance use disorder treatment records are protected under federal law,including 42 CFR Part 2 and HIPAA, and any applicable state laws. My treatment records can only be used or disclosed with my written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state law. By signing below, I give consent to release the records as indicated above.

I understand that consenting to the disclosure of treatment information is voluntary. I can refuse to sign this consent and it will not impact my ability to receive treatment at CODA except as noted below. If I chose not to consent to the disclosure of my records with my outside healthcare providers for treatment purposes, I understand there may be disruptions or delays to the coordination of my care. If I chose not to consent to the disclosure of my records for payment purposes, I understand CODA will not be able to receive payments from my health insurance and I may be responsible for all payments. CODA may condition my ability to receive treatment on such payment.

I may revoke this release, except to the extent that a use or disclosure was made prior to the time I revoked it, by sending a written request to CODA's Medical Records Department via email to ROIRequests@codainc.org or by mail to 1027 E. Burnside St., Portland, Oregon, 97214.

I have been offered a copy of this form. It has been explained to me in a language I understand. I acknowledge that there is a potential for the records used or disclosed pursuant to this consent to be subject to redisclosure by the recipient and no longer protected by Part 2.

I understand that, unless I revoke this release, it will expire 180 days after my last date of treatment, services, or clinical contact related to the purpose of this authorization, if no date or event is specified here: [Optional]______________________________________.

______________________________________ ______________
Signature of patient or legal representative: Date:

If a Legal Representative, what is your authority to act for the patient? ______________________

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RELEASE OF INFORMATION INSTRUCTIONS

1. Always print name and birthdate clearly.
2. Always sign and date the form.
3. Completely fill out the information of the organization and/or name of the individual to whom information will be released.
4. Please review all records to be released and make any preferred changes.
5. Purpose of Disclosure must be noted (some examples: Coordination of Care, Legal Services, etc.).
6. If there is any reference to (AIDS) or HIV, Behavioral Health Services, or Mental Health Services in the information that is being released, the patient may chose to not disclose that information by removing the prefilled selections.
7. The date or event by which the ROI will expire is optional - it will expire 180 days from the last date of treatment, services, or clinical contact if no date or event is specified
8. The patient must sign with their full legal name.
9. If the patient has legal representation, legal court documentation assigning such legal representation must be submitted along with the signed ROI.

Please submit this completed form, or any questions on how to fill it out, to CODA's Medical Records Department at ROIRequests@codainc.org or call 1 (855) 733-2632 and ask for the Medical Records Department.