



Lane County Health and Human Services  
Developmental Disabilities Services

Authorization for Release of Confidential Information

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Name of agency, institution or individual to provide information to and/or receive information from: \_\_\_\_\_

Name, address, phone and fax number of agency to provide information to and/or receive information from:

**Lane County Developmental Disabilities Services**  
125 E. 8<sup>th</sup> Avenue, Eugene, OR 97401  
Phone: (541) 682-3695 Fax: (541) 682-3879

Purpose of disclosure: \_\_\_\_\_

Nature of information to be disclosed: \_\_\_\_\_

**HIPAA client rights:**

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- a. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization; however, certain health records may be needed to determine eligibility for services from the Lane County Developmental Disabilities Services program
- b. You may refuse to sign this authorization

You have the right to revoke this Authorization at any time, either in written or oral form, and except to the extent that we have already used or disclosed the information in reliance on the Authorization

Unless revoked earlier or otherwise indicated, this Authorization will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request or in cases where records are in process of transmittal or have been transmitted before notification of revocation

*I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure and no longer be protected under state and federal law. However, I understand that the recipient may be restricted from redisclosure of certain information (i.e.: drug and alcohol, HIV, mental health) without my further authorization.*

Signature of client \_\_\_\_\_ Date \_\_\_\_\_

OR

Signature of client representative \_\_\_\_\_ Date \_\_\_\_\_

Description of representative's authority \_\_\_\_\_ Date \_\_\_\_\_

I recognize that the information released may contain drug/alcohol information that is protected by federal and state law. I specifically consent to the release of the following types and amounts of information (i.e. attendance, treatment plan, discharge):

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I recognize that the information released may contain information regarding HIV/AIDS testing, treatment, or high-risk behavior. I specifically consent to its release:

Signature

Date

I recognize that the information released may contain mental health information. I specifically consent to its release.

Signature

Date

*'This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.'* 42CFR Ch. 1, Subpart C, 2.32 prohibitions on redisclosure.