Lane County Health & Human Services
Public Health – WIC Program
151 W 7th Avenue, Room 210 Eugene OR 97401
Phone 541-682-4202 Fax 541-682-4248

Authorization for Release of Confidential Information

Client Name: Date of Birth:

WIC ID:

I authorize the release of my confidential medical and nutritional reports and records by Lane County Public Health WIC Program to any of the designated agencies or individuals listed below. Designated agencies and individuals may also release confidential information to Lane County Public Health or other designated agencies or individuals.

Please check √ YES or √ NO for each agency and initial each response.

√ YES	√ NO	Initial	Agency/Provider
			Personal physician (name and phone #)
			Child Development and Rehabilitation Center (CDRC)
			Early Childhood Cares (EC Cares) – Early Intervention
			Food for Lane County
			Other
			Other

Purpose of Disclosure: Continuity of care and coordination of services.

Nature of information to be disclosed: Height, length, weight, head circumference, HGB values, feeding plans, and immunization records.

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 treatment, payment, enrollment, or eligibility for benefits on the receipt of this signed authorization;
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 were 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

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):

_____

_____

Signature _____Date _____

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 42 CFR 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'. 42 CFR Ch. 1, Subpart C, 2.32 Prohibitions on redisclosure.