|  |  |
| --- | --- |
| Client Legal Name: (Last, First, MI) |  |
| Preferred Name: |  |
| MRN: |  |
| DOB: |  |

**Authorization to Use and Disclose Protected Health Information**

I understand that my healthcare provider is participating in a pilot project called Rapid Engagement. During the project, my provider is testing out a new way for clients to begin services. The goal of this project is to make it faster and easier to get started with behavioral health services. Some information collected will be shared with study partners so that they can help decide whether this approach works better for people seeking treatment. The study partners in the project will not have access to my name, medical record number, or any kind of treatment notes about me.

**By signing this form, I authorize:**

|  |  |
| --- | --- |
| Provider Organization Name |  |
| Provider Organization Address |  |

**To disclose the following specific confidential information about me:**

**PLEASE INITIAL EACH LINE**

|  |  |  |  |
| --- | --- | --- | --- |
| I authorize release of: | Additional Information to be disclosed: | | |
| \_\_\_\_\_ Substance Use Disorder   Diagnosis and Treatment  \_\_\_\_\_ Mental Health Diagnosis and   Treatment | * Gender * Race * Ethnicity * Age | * Highest grade completed * Interpreter * Tribal Affiliation * Pregnancy status | * Living arrangement * Date of screening and assessment appointments for mental health or SUD treatment |

**To these study partners:**

* University of Oregon, 1600 Millrace Dr., Eugene, OR 97403
* Assoc. of Oregon Community Mental Health Programs, 102 Liberty St. NE #140, Salem, OR 97301

**For the purpose of:**

Evaluation of the Rapid Engagement pilot, funded by Oregon Health Authority Grant Agreement Number 173961, in order to improve the behavioral health system for Oregonians.

**SIGN HERE**

|  |
| --- |
| This authorization becomes effective on the date below and will continue until the end of the pilot project (no later than June 30, 2023) or until I cancel it. I understand that I can cancel this authorization at any time by providing written notice of cancellation to the above-identified record holder(s).  Any cancellation will not affect information that was disclosed before my cancellation notice was received by the record holder(s).  I understand that information disclosed based on this authorization may be shared by the recipient and no longer protected under federal or state law, EXCEPT THAT the recipient of information related to HIV/AIDS, mental health, alcohol or drug treatment, or genetic testing information may not share it again without my authorization or as otherwise permitted by federal or state law.  I understand I may refuse to sign this form.  **I know that my provider cannot deny me services if I do not sign this authorization.**  I am not acting under pressure or threat.  I have been offered a copy of this form and I have reviewed my provider’s written Notice of Privacy Practices. |
| Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_  **-- OR --**  Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_  Representative’s Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Representative’s Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |