TILLAMOOK FAMILY COUNSELING CENTER
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
Updated 10/18/2023

SECTION A: The name of the person, or class of persons, who may authorize the requested use or disclosure.

I, _____or my authorized representative, authorize Tillamook Family Counseling Center to use and/or disclose my protected health information as described in Section B below**.** I understand that:

1. If I am a mental health or public health client, my treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this use or disclosure, and
2. I am entitled to a copy of this authorization.

SECTION B: Entities Authorized to Receive or disclose the Individual's Protected Health Information:
Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing to use and/or disclose the protected health information described below in section C:

_____ _____

_____ _____

SECTION C: Protected Health Information to Be Used and/or Disclosed:
Specifically, and meaningfully describe the protected health information you are authorizing to be used or disclosed.

_____

_____

SECTION D: Purpose of the Use or Disclosure:
Describe the reason for the use or disclosure of this information. The statement "at the request of the individual" is a sufficient description of the purpose when you initiate the authorization and do not or elect not to provide a statement of the purpose.

_____

_____

SECTION E: Expiration and Revocation.
This authorization will expire (complete one):

1. On _____/_____/_____
2. On occurrence of the following event (which must relate to you or to the purpose of the disclosure being authorized): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the TFCC Records Clerk. I understand that revocation of this authorization will *not* affect any action TFCC took in reliance on this authorization before receipt of my written notice of revocation.

Contact Office: TFCC Records Clerk
Ph. 503-842-8201 ext. 0 Fax: 503-815-1870
Address: 906 Main Ave, Tillamook, OR 97141

SECTION F: Signature

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organization named in this form the protected health information described in this form.

_____	_____	_____
Signature	Date	Date of Birth

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Description of Authority to Act for the Individual: _____

SECTION G: Prohibition of Redisclosure

NOTICE PROHIBITING REDISCLOSURE OF PROTECTED HEALTH INFORMATION
The recipient of the health information described above is prohibited from making any further disclosure of this information unless expressly permitted to do so by the written consent of the person or his/her personal representative who is authorizing its use or disclosure. [ORS 174.505(14) and 42 C.F.R. 2.32]

On occasion, TFCC's records may contain records created by another health care provider. Under 42 CFR Part 2, TFCC may only disclose Substance abuse records if the client signs a consent form that explicitly authorizes both the disclosure of TFCC's records and the redisclosure of the other health care provider's records.