Fora Health
10230 SE Cherry Blossom Dr.
Portland, OR 97216
P: (503) 535-1151

Authorization for the Release of Confidential Information (ROI)

General

Patient Name:	Fora Health Medical Record Number:	DOB:
Effective Date (mm/dd/yyyy):	**This Authorization ends 1 year from Effective Date, unless other condition, event, or date is indicated here:**	
I hereby authorize 2-way communication between Fora Health and:		
Name or Organization/Entity:	**Relationship to Patient:**	
Authorization includes but is not limited to the following contact person:	**Telephone:** **Email:** **Fax:**	

The **purpose of this exchange** is: _____

By signing this form, I agree for Fora Health to admit to my presence in the Substance Use Disorder Treatment Program (only "enrolled" or "discharged.") If the information to be disclosed contains of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand that this information will be disclosed **only if I place my initials in the applicable space next to the type of information.**

Patient Initials	*Primary Type of Information to be Disclosed (must be initialed to be valid)*
	Substance Use Disorder Treatment, Evaluation, or Referral

The information may be disclosed as indicated below: (Note: Above Substance Use Disorder Treatment box MUST be initialed for the choices below to be valid.)

Y ☐	N ☐	Evaluation Recommendations	Y ☐	N ☐	Progress in Treatment
Y ☐	N ☐	Discharge / Transfer Summary Plan	Y ☐	N ☐	Urinalysis / UDS Results
Y ☐	N ☐	Alcohol & Drug Assessment	Y ☐	N ☐	Waiting List Status
Y ☐	N ☐	Treatment Sessions Attended	Y ☐	N ☐	Other Medical Information
Y ☐	N ☐	Other:			

Patient Initials	*Secondary Type of Information to be Disclosed (each must be initialed to be valid)*
	Mental Health Treatment, Evaluation, or Referral; and/or Mental Health Assessment, Screening, or Psychological Evaluation
	HIV and AIDS Status / Information

Required Statements:

- I understand that my substance use disorder treatment records are protected by (i) federal regulations located at 42 CFR Part 2 that govern confidentiality of substance use disorder treatment patient records, and (ii) the Health Insurance Portability and Accountability Act (HIPAA) and related regulations located at 45 CFR Parts 160 & 164 (collectively, the "Federal Privacy Regulations").
- I understand that my substance use disorder treatment records cannot be disclosed without my written authorization unless otherwise permitted by applicable Federal Privacy Regulations.
- I understand that disclosures may be made pursuant to this authorization. I also understand that the recipient of the information may re-disclose the information such that it may no longer be protected by the Federal Privacy Regulations, unless the information is alcohol/drug information that may not be redisclosed under 42 CFR Part 2.
  I understand that Fora Health is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.
- I understand that I may revoke this authorization at any time, except to the extent that Fora Health or its staff have already taken action in reliance on it. Revocation may be in writing and should be sent to Records@forahealth.org.

Fora Health
10230 SE Cherry Blossom Dr.
Portland, OR 97216
P: (503) 535-1151

Authorization for the Release of Confidential Information (ROI)

General

Signature of Patient	Date
Signature of Parent, Guardian, or Authorized Representative (if required)	Date
Signature of Witness	Date
Printed Name of Witness	Date

Notice to recipient of patient records:

This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies:

(i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2.

(ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or

(iii) You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E.

A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).