Print Form

Oregon Commission for the Blind
535 SE 12th Ave
Portland, OR 97214
(971)673-1588 Fax: (503)234-7468

Release of Information Request

To:

RE:
Date of Birth:

I authorize you to release the specified information to the Oregon Commission for the Blind. (Initials:___)

I authorize the Oregon Commission for the Blind to release the specified information to you. (Initials:___)

Eye information (diagnosis, best corrected visual acuities, prognosis, visual fields) (Initials:___)

Medical information (Initials:___)

HIV/AIDS information (Initials:_____)

Drug/Alcohol diagnosis, treatment information (Initials:_____)

Mental Health information (Initials:_____)

Academic/Vocational information (Initials:_____)

Other information: (Initials:_____)

Confidentiality Statement

This information will be used by the Oregon Commission for the Blind to establish my eligibility for services and/or to plan and provide services which I will need. Federal law protects the sharing of health information but if I choose to share information with an agency or business not covered by the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule, then they could share information with others. The Oregon Commission for the Blind is not a HIPAA covered entity. The Oregon Commission for the Blind adheres to other federal and state rules and will not release information to a third party without my permission.

I may revoke this authorization at any time by submitting a request. Any disclosure already made with my permission cannot be undone.

I understand that this information may be necessary to determine eligibility for and appropriate planning of services. If I choose not to authorize the disclosure, I may not be able to show that I qualify for services from the Oregon Commission for the Blind or services may be delayed while new information is obtained.

This release expires one year from date of signature unless a written revocation request is received prior to the expiration.

_____

Client Date

_____

Legal or Personal Representative Date

Revocation Request

I would like to revoke this authorization for the release of information as of _____. (Initials:____)