

**LINN COUNTY ADULT SERVICES TEAM
AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION**

Name: _____ DOB: _____

The purpose of this Authorization Form is to enable agencies identified as members of the Linn County Adult Services Team to better serve me through coordinated service planning and delivery. Representatives of these agencies will meet and share information regarding me at scheduled planning and review meetings. In addition, this release will permit follow-up case coordination between the listed agencies.

The Linn county Adult Services Team shall include the following agencies:

Albany Helping Hands	Linn County Parole and Probation
Albany Police Department	Linn Benton Housing Authority
Community Services Consortium (CSC) including utility assistance	Linn County Sherriff
DHS Self-Sufficiency	Love INC of Linn County
Linn County Mental Health Services	Samaritan Health Services
Linn County Alcohol and Drug	Senior and Disability Services

Other: _____

The information which may be disclose/exchanged is: presence in the program, legal and treatment records which include assessment, family history, medical history, diagnosis, treatment history and recommendations including those from the Linn County Mental Health and Alcohol and Drug Treatment Programs.

This release authorizes a free exchange of information between members in order to offer the most complete and thorough services available. It does not authorize release to any other person or agency except those agencies listed above. Unless revoked, this release and exchange shall remain in force for a period of 12 months from the date of authorization or six (6) months following the completion of services with a given agency.

To the agency/designee receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR Part 2) and HIPAA prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

I also understand that no one can disclose HIV information about me, except as required or permitted by federal or state law or rule, or with my written permission.

By signing this form, I am authorizing the release of protected information between and among the identified Linn County Adult Services Team members.

Authorized Signature

Date

Witness

Date