Outside In

Attn: Youth Department
1132 SW 13th Avenue, Portland, OR 97205
Main: (503) 535-3800 ■ Records: (503) 445-0984;
FAX (503) 535-3868 ■ Email: records@outsidein.org

PERMISSION TO RELEASE AND RECEIVE INFORMATION OR RECORDS

First Name _____ **Last Name** _____

Other Names Used _____ **DOB:** _____/_____/_____ **Email:** _____

I authorize Outside In to: ❒ **get information** ❒ **give information** ❒ **Get *and* give information**

From/To Name of Individual	Facility or Organization	Phone	Fax

Street Address	City, State	Zip Code

I authorize sharing of:

❒ **Past Records**
❒ **Future Records**
❒ **Verbal Exchange of Information**

Records authorized from _____ (date) to _____ (date)

❒ as often as needed ❒ for this one-time use only

For the purpose of:

❒ To Plan/Coordinate Services ❒ Ongoing Exchange of Information ❒ To Assist in Evaluation ❒ To Report Evaluation
❒ Treatment/Continuity of Care ❒ At my request ❒ Other:_____

By initialing below, I authorize release of the following information:

_____ **All health records** (will not include HIV/AIDS, Drug/Alcohol or Mental Health **unless also initialed below**)
_____ **HIV/AIDS:** related testing, results, referrals, and counseling
_____ **Drug/Alcohol**: Includes evaluation, diagnosis, treatment plan, prognosis and progress to date, chart notes, medication monitoring, billing, payment, utilization management, and care coordination
_____ **Mental Health**: Includes evaluation, diagnosis, treatment plan, prognosis and progress to date, chart notes, medication monitoring, billing, payment, utilization management, and care coordination

Provider or Patient (indicate actual records needed): ❒ **Progress Notes only** ❒ **last 3** ***or*** ❒**from** _____ **to** _____
❒ **Problem List** ❒ **Medication List and Prescription Monitoring** ❒ **Relevant Family Planning**
❒ **Lab results (specify):** _____ ❒ **Imaging** *reports* **(specify):** _____ ❒ **Other:**

Desired Format (if requesting records for self):

❒ Secure Email (free) ❒ Faxed/Electronically sent (free) ❒ Mail (fees may apply) ❒ Printed (fees may apply)

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on the authorization. I understand I may refuse to sign the authorization and such refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. To revoke this authorization, please provide a written statement to Medical Records c/o Outside In and state that you are revoking a previous authorization. This consent will expire 1 year from the date I sign, unless revoked earlier or timeframe less than 1 year indicated with box checked: ❒ upon the event or date indicated _____
The information released pursuant to the authorization may be protected by 42 CFR Part 2, 45 CFR Part 160 and Subparts A and E of Part 164 and applicable State law (ORS 179.505, 192.525).

Signature of client or authorized representative	Relationship to client	Date
		_____/_____/_____

To be Completed by Outside In Staff Only:

Outside In Medical Records please (*check only those that apply*): ❒ No action required (ROI will be filed for future use)
❒ ***Send*** records indicated ❒ ***Request*** records indicated

Name of provider or clinician requesting records: _____

Check this box if records being released originate in RISE/ROSE which can only be released with specific client authorization.
❒ **The records requested are protected by federal confidentiality rules (42CFR Part 2). Re-disclosure is not authorized.**

Comments:

Accepted by: