RESOURCE CONNECTIONS OF OREGON

RELEASE OF INFORMATION

I, ______________________________ ____________________ ,
(NAME) (DOB)

give my consent to Resource Connections of Oregon to **OBTAIN INFORMATION FROM/PROVIDE INFORMATION TO:**

____

This confidential information may include:

initials	
________	Diagnosis, service eligibility and service enrollment status
________	Medical, psycho-social, and behavioral history
________	Psychological/psychiatric testing and/or evaluations
________	ISP/IEP and other support plans
________	Financial needs and/or benefits
________	Fiscal Intermediary (Employer/Employee) services
	Current service needs
________	All of the above
________	________
________	________

The purpose of such information is:

- Obtaining, maintaining and/or coordinating services.

I understand that this release can be revoked at any time, except for action already taken. Unless another date is specified, this release will expire twelve (12) months after it is signed.

Time Limitation of Release: ______________________________

To the party receiving this information: This information has been disclosed to you from confidential records protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further discloser of it without the specific written consent of the person to which 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.

Signed: ______________________________ Date: ______________
Customer

Signed: ______________________________ Date: ______________
Legal Guardian

Signed: ______________________________ Date: ______________
Witness