



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 disclosure 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