Housing Authority and Urban Renewal
Agency of Polk County

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HOUSING PROGRAMS RELEASE OF INFORMATION

Authorization for Use or Disclosure of Protected / Confidential Information

Client Information		
Client's Full Name:		
Date of Birth:		
Primary Phone Number:		
I hereby authorize West Valley Housing Authority to: ☐ DISCLOSE INFORMATION TO ☐ OBTAIN INFORMATION FROM		
Name:		
Primary Phone Number:	Fax:	
Address:		
City:	State:	ZIP:

☐ DHS or their Attorney ☐ Parole / Probation Officer

☐ Polk County Resource Center ☐ Polk County Family & Community Outreach

☐ Polk County Behavioral Health ☐ Emergency Contact

☐ Other (specify):_____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol ordrug abuse patient.

Purpose of the Disclosure of Information:

☐ Scheduling of Appointments ☐ Legal Proceedings

☐ Evictions / Terminations ☐ Income / Asset / Expense Calculations

☐ Inspections / Findings ☐ Emergency Contact

☐ Other (specify):_____

Expiration: This permission is valid for no more than 90-days from the date of my signature.

CONTINUED ON REVERSE SIDE

- I may revoke this authorization in writing by presenting my written request at any West Valley Housing Authority office location. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I may refuse to sign this authorization.
- I may inspect or copy (at my own expense) any information used and/or disclosed under this authorization.
- Information used or disclosed by this authorization may be subject to re-disclosure and may no longer be protected under federal or state laws EXCEPT for sensitive medical information.

I have read this authorization and I understand it.

_____ _____

Signature of Client / Parent / Legal Guardian Date

Relationship to Client: ☐ Self ☐ Parent or ☐ Legal Guardian (proof of guardianship required)

_____

Printed name of the person signing

_____ _____

Signature of Witness Date

Using This Form

1. **Assistance:** Whenever possible, a WVHA staff person should assist you in filling out this form. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
2. **Guardianship / Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.
3. **Cancel:** If you later want to cancel this authorization, contact your assigned WVHA staff person. You may be asked to put the cancellation request in writing. Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No further information can be disclosed or requested after authorization is canceled. WVHA may continue to use information obtained prior to cancellation.
4. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
5. **Re-disclosure:** Federal regulations (42 CFR Part 2) prohibit making any further disclosure of Alcohol and Drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.
6. **Privacy Practices**: All clients who enroll in services will be provided, upon request, a copy of WVHA privacy practices, which outlines how we may share protected information, client rights, and how to file a complaint or report a suspected problem.