Oregon MothersCare
Office of Family Health
800 NE Oregon St., #825
Portland, Oregon 97232
Phone (503) 731-4021
Fax (503) 731-4091

Oregon MothersCare Authorization para Divulgar Información

Oregon MothersCare
supporting healthy pregnancies

A nuestros clientes: Al firmar este formulario, Ud. nos autoriza a intercambiar información sobre referencias y de otro tipo con las siguientes agencias, programas o servicios.

Nombre legal: _____
Apellido Nombre Inicial

Autorizo a _____ a divulgar información sobre referencias y de otro tipo a:

Sitio de Oregon MothersCare

Inicial de la cliente	/	
		M.D./Provedor *En el espacio de abajo, escriba el nombre completo y la dirección del médico o proveedor:*
		Departamento de Salud de Condado de Nombre del condado
		WIC
		OMAP / Plan de Salud de Oregón

Doy mi permiso para que las agencias/programas/servicios* antes nombrados compartan e intercambien información sobre mi situación.

Escriba sus inciales en uno de los dos: Sí No

Puedo cancelar esta autorización de divulgación de información en cualquier momento, pero entiendo que la cancelación no afectará la información divulgada antes de la cancelación. Entiendo que la información sobre mi caso es confidencial y está protegida por leyes estatales y federales. Autorizo la divulgación de esta información. Entiendo lo que significa este acuerdo. Firmo por mis propios medios y no he sido presionada para hacerlo. Esta autorización para divulgación de información vence 6 semanas después de la fecha de mi parto.

_____
Firma legal completa Fecha

_____
Un testigo Fecha

*Para quienes reciban información bajo esta autorización: La información que Ud. recibió está protegida por leyes estatales y federales. Usted no la puede divulgar a agencias o personas que no estén nombradas en este formulario sin el consentimiento específico por escrito de la persona a quien pertenece.

_____ This is a true copy of the original document.
Full signature of agency staffperson making copies

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Instructions

1. The OMC worker should fill out this form for the client. Be sure the client understands it before signing. Encourage the client to ask questions about the form and what it allows.

2. **Cannot read/Cannot write**: A client may substitute a signature with making a mark or by asking someone to sign on his/her behalf.

3. This is a **Voluntary Form**. However, clients should be given accurate information on how the refusal to allow the release of information may adversely affect eligibility determination or coordination of services.

4. **Duration**. The authorization is valid for one year unless otherwise specified.

5. **Records**. This release covers information about the person signing the form.

6. **Revocation**. If the person later cancels this authorization, write "revoked" and the method and date of revocation boldly across the form. Date and initial it, and keep in the file. Federal regulations do not allow us to require that the revocation be in writing.

7. **Mail Requests**. If this form is being used to request information by mail, be specific about what you need. If you have a series of questions, use a cover letter. The clearer you are in your request, the more likely you are to receive a prompt and accurate response. Do not ask for information you do not need.

8. **Photocopying. Keep the original in the file** and send copies to other agencies. The person making the photocopies should sign each copy at the bottom of the first page certifying it as a true copy. The agency receiving the authorization should reject it if there is not an original signature by the person who made the copy.

***Special Attention*:**

9. **Redisclosure**. Information received under this authorization should not be redisclosed to any party not identified on this form without specific written consent. Criminal penalties may apply to illegal disclosure. Federal regulations (42 CFR part 2) prohibit you from making any further disclosures of Alcohol and Drug information and state rules OAR 333-12-270, ORS 433.045 prohibit further disclosure of HIV/AIDS information, and statutes ORS 659.700-659.720 and OAR 333-24-0500 through 0560 prohibit further disclosure of Genetics information 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 information is not sufficient for this purpose.

10. **HIV/AIDS**. A general release is not sufficient. Identification of a specific individual, agency, or facility is required, including third party payers, a specific purpose for the release, and a specific time period are necessary.

11. **Genetics**. A general release is not sufficient for genetic test results but is sufficient for general historical information. OAR 333-024-0550 (Appendix 2) requires use of a specific genetic release form for disclosure or redisclosure. Provision of the specified form to the tested individual is required.