



CSS CONSENT TO RELEASE PERSONAL INFORMATION

To be valid, this form must be filled out COMPLETELY, including what information you are giving permission to share.

Name: _____ Date of Birth: _____

I hereby authorize CSS (also known as Coastal Support Services) to share: Please initial

- _____ Any of my medical information, including information about:
 - _____ Drug and alcohol use and history _____ Medication(s)
 - _____ Sexual transmitted disease(s) _____ HIV/ AIDS
 - _____ Mental health _____ Pregnancy

The following information: (specify) _____

The purpose of this authorization form is to enable agencies identified as Community Partners to better serve me through coordinated service planning and delivery. By signing this form, I understand that representatives of these agencies will share information regarding me at scheduled planning and review meetings or over the phone. In addition, this release will permit follow-up case coordination between the listed agencies.

The agencies may include:

Lincoln County Health & Human Services	Lincoln County Drug and Alcohol	Reconnections
Community Services Consortium (CSC)	Lincoln County Mental Health	Samaritan House
Department of Human Services (DHS)	Love INC of Lincoln County	DHS Self Sufficiency
Senior and Disability Services	LBL Education Service District	Helping Hands
Lincoln County Sheriffs	Newport Police Department	Lincoln City Police Department
InterCommunity Health Network (IHN-CCO)	Lincoln County Drug Court	Lincoln County Hope Court
Samaritan Health Services	Powerhouse Detox	Phoenix Wellness Center
Lincoln County Parole & Probation	Lincoln County Jail	NW Coastal Housing

OTHER: _____

This consent allows mutual exchange between CSS (Coastal Support Services) and the agencies listed above.

It does not authorize release to any agency or person not listed.

This release authorizes the exchange of the aforementioned information between CSS (Coastal Support Services) and other community partners.

I understand that I may revoke this authorization at any time by contacting CSS (Coastal Support Services) and signing off my desire to revoke this authorization. Unless revoked, this release and exchange shall remain in force for a period of two (2) years from the date of authorization.

CONFIDENTIAL: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation (42 CFR, Part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such information.

By signing this form, I am authorizing the release of protected information

Signature: _____ Date: _____

CSS Staff: _____ Date: _____

Revoke ROI Signature: _____ Date: _____