!	Authorization **REVOKED** on: ________________ ☐ Verbally by Client ☐ in Writing by Client Staff Signature: ______________________________

AUTHORIZATION TO DISCLOSE AND USE PROTECTED HEALTH INFORMATION CONTAINED IN AN INTEGRATED HEALTH RECORD

Name: ____________________________, ______________________________, ____________ Date of Birth: ____________________________________
Last Name First Name Middle Initial

RECIPIENT (Person or agency to and/or from whom Lifeways may receive and/or disclose my protected health information)	
Name of Person or Agency:	Umatilla Wraparound Review Committee 97801, 97838, 97882, 97868, 97810, 97813, 97826, 97835, 97859, 97875, 97886, 97880
Address of Person or Agency:	

☐ ____ I understand that Lifeways has an integrated health record which allows mental health staff access to information related to substance use treatment or any other services I receive from Lifeways': I am therefore authorizing Lifeways staff members who need access to my protected health information to access the minimum necessary information in my record for such purposes. This is with the assurance that my substance abuse treatment information will not be reviewed in detail and the fact that I am receiving substance abuse treatment will not be disclosed to other programs outside of Lifeways without my explicit written authorization, unless required by law.

TYPE OF INFORMATION TO SHARE

By checking and initialing any of the lines below, I specifically authorize the disclosure and use of the type of protected health information I have checked and initialed.

☐ ____ Developmental Disability Assessment	☐ ____ Mental Health Assessment
☐ ____ Developmental Disability Progress	☐ ____ Mental Health Progress Notes
☐ ____ Educational Records	☐ ____ Mental Health Discharge Summary
☐ ____ General Medical Records (including lab results)	☐ ____ Psychiatric Assessment
☐ ____ Information about Child Abuse and Neglect	☐ ____ Psychiatric Progress Notes
☐ ____ Information Necessary to Arrange Transportation	☐ ____ Psychiatric Discharge Summary
☐ ____ Information Necessary to Deal with an Emergency	☐ ____ Substance Abuse Assessment
☐ ____ Information about Sexual Assault	☐ ____ Substance Abuse Progress Notes
☐ ____ Information about Sexually Transmitted Diseases	☐ ____ Substance Abuse Discharge Summary
☐ ____ Information about HIV/AIDS-related Testing (Including the fact that an HIV test was ordered or reported, regardless of whether the results of such tests were positive or negative)	☐ ____ Urinalysis Results ☐ ____ Other: ________________________________

DATE, EVENT, OR CONDITION UPON WHICH THE CONSENT WILL EXPIRE

☐ ____ ***I understand that I can revoke this authorization at any time by notifying Lifeways in writing or verbally of the revocation. I understand that revoking this authorization will not affect information that has previously been disclosed in reliance upon this authorization.***

By initialing one of the lines below, I specifically authorize disclosure and use of the type of information indicated above by my initials for the term I have checked and initialed below.

This authorization will remain in effect: ☐ ____ for one year from the date of this authorization.
☐ ____ other: ____

PURPOSE OF THE AUTHORIZATION

The protected health information covered by this authorization may be used only for the purposes I have checked and initialed below:

☐ ____ To assess eligibility and need for treatment ☐ ____ To plan and coordinate treatment

I am: ☐___the person whose protected health information is covered by this authorization.
☐___the parent of the minor child whose protected health information is covered by this authorization.
☐___the legal guardian or custodian of the person whose protected health information is covered by this authorization.
☐___authorized to sign by a currently valid health care power of attorney.

I have read and understand the terms of this Authorization to Disclose, Receive and Use Protected Health Information. By my signature below, I voluntarily authorize disclosure, receipt and use of my protected health information as indicated above. I can revoke it at any time by notifying Lifeways in writing or verbally. I understand that the information disclosed in reliance on this authorization may be subject to re-disclosure and will no longer be protected by federal law. Refusal to sign this authorization will not adversely affect a person's ability to receive services.

______________________	______________________	______________________
Printed Name of Authorizing Person	Signature of Authorizing Person	Date Signed
Printed Name of Witness	Signature of Witness	Date Signed

Information disclosed from any alcohol and drug abuse treatment records is protected by federal confidentiality rules (42 CFR part 2 and 45 CFR parts 160 and 164) and cannot be re-released in reliance upon this authorization. Federal rules prohibit anyone 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 release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of alcohol and drug treatment information released to criminally investigate or prosecution purposes.

Eastern Oregon Coordinated Care Organization

WRAPAROUND COORDINATED CARE REFERRAL

Umatilla County

IMPORTANT: please fill out this form thoroughly, and be prepared to answer follow up questions or present the information to a committee member.

Person(s) Making Referral: ____ **Date:** ______________

Agency: ______________________________ **Contact Info:** _______________________________________

Behavior/Concerns/Reason for Referral: (please include criminal history, school issues, family dynamics, current living situation, etc.) ____

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Interventions/Supports CURRENTLY accessing (minimum of 2 required)

- ☐ EOCCO #__________________
- ☐ CARE
- ☐ REACH
- ☐ DHS/Child Welfare
- ☐ Behavioral Health
- ☐ Head Start
- ☐ Juvenile Justice
- ☐ Dev. Disabilities
- ☐ _________________________
- ☐ _________________________
- ☐ _________________________
- ☐ _________________________

Select ALL that apply. *If you select YES, you MUST provide additional comments/explanation/evidence*

Additional Considerations	**YES?**	**Comments/Explanation**
Significant risk of losing current placement and/or multiples moves within the system		
Youth is displaying emotional and behavioral issues; there are social concerns		
School disruption due to suspension and/or expulsion		
Permanency status in question (adoption, new relative placements, etc.)		
Elevating risk of harm to self or others (including sexualized behaviors, fire setting, etc.)		
Youth has medical condition(s) that may be impacting/contributing to behavioral challenges		
Parent/Caregiver is experiencing stress/burnout		

REVIEW COMMITTEE DECISION Date: ______________

Accept ____ Decline ____ Reconsider in 1 month ____

Eastern Oregon Coordinated Care Organization

WRAPAROUND COORDINATED CARE REFERRAL

Umatilla County

Family Demographics

(continued from the front)

Youth Name:____ DOB:______________ Age:_____ Gender: ____

Address:____ Phone: ____

Mother

Name: ____

Address:______________________________________

____

Phone:____

Email:____

Employer:_____________________________________

Father

Name:____

Address:______________________________________

____

Phone:____

Email:____

Employer: _____________________________________

*If parents not legal guardians, please provide the following info:

Legal Guardian: ______________________________________ Phone: ______________________________________

Address: ____

Siblings:

Name	Gender	Age	Lives with whom?	School

Any additional family dynamics/concerns not already described?

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Strengths of Youth:

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Strengths of Family:

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