AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION (PHI)

Help Me Grow Oregon

FAMILY/CHILD INFORMATION

Parent/Guardian Name:	Child's Name:
Relationship to Child:	Child's DOB:
Address:	Insurance:
City, State, Zip:	Preferred Language:
County:	☐ Bilingual/English ☐ Needs Interpretation
Phone: Phone:	Email:

AUTHORIZATION TO USE PHI

AUTHORIZATION IS ONLY VALID IF THIS RECORD IS COMPLETED IN FULL

For continuity of care I authorize the use and disclosure of my child's development records as stated below:

PHI To/From:	**Disclose PHI To/From:**
Name: _____ Address: _____ _____ Phone: _____ Fax: _____	Help Me Grow Oregon at Swindells Resource Center 830 NE 47th Avenue Portland, OR 97213 Phone: 833-868-4769 Fax: 503-487-3585

Parent/Guardian Signature:_____ Date:_____/_____/_____

Your consent is effective until revoked in writing.

REASON FOR REFERRAL TO HELP ME GROW

PLEASE COMPLETE ALL THAT APPLIES AND ATTACH COMPLETED SCREENING TOOL

ASQ Screen: ☐ 9 month ☐ 18 month ☐ 24 month ☐ 30 month ☐ Other: _____

☐ Communication ☐ Gross Motor ☐ Fine Motor ☐ Problem Solving ☐ Personal-Social

Early Intervention/Special Education: ☐ Eligible ☐ Not Eligible ☐ Unknown ☐ Not Applicable

Recommendations:_____

_____

_____

_____

Provider Name: _____ **Signature**: _____ **Date**:_____/_____/_____

HELP ME GROW Oregon

PROVIDENCE CHILD CENTER | SWINDELLS RESOURCE CENTER
830 NE 47th Ave. Portland, OR 97213 | Phone: 833-868-4769

received by
HMG Resource Specialist:_____ Signature:_____ Date:_____/_____/_____

PROVIDENCE Children's Health

I understand the following:

- I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/ AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.
- I have the right to receive a copy of this signed authorization.
- I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when PH&S has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

To revoke this authorization, send a written statement stating you are revoking this authorization along with a copy of this authorization to:

Name:
Address:
City:
State & Zip:

Providence Health & Services and its Affiliates do not discriminate on the basis of race, color, national origin, sex, age, or disability in their health programs and activities. Providence Health & Services no longer print or release patient social security numbers unless required for billing. However, social security numbers may be included in patient information that is more than a few years old. The information you are authorizing to be released may include your social security number.
The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.