LINN COUNTY ADULT SERVICES TEAM
AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

Name: _____ DOB:_____

The purpose of this Authorization Form is to enable agencies identified as members of the Linn County Adult Services Team to better serve me through coordinated service planning and delivery. By signing this form, I understand that representatives of these agencies will meet and share information regarding me at scheduled planning and review meetings. In addition, this release will permit follow-up case coordination between the listed agencies.
The Linn County Adult Services Team shall include the following agencies:

Albany Helping Hands	Albany Police Department	Lebanon Police Department
Love INC of Linn County	Linn County Sheriff	Linn County Parole and Probation
CHANCE	Linn-Benton Housing Authority	Linn County Alcohol and Drug
Community Services Consortium (CSC	Senior and Disability Services	Linn County Developmental Disability Services
Family Tree Relief Nursery	DHS Self-Sufficiency	Linn County Mental Health Services
Jackson Street Youth Services	LBL Education Service District	The Greater Albany Public School District 8J
Albany Partnership for Housing & Community Development		Signs of Victory
The Boys and Girls Club of the Greater Santiam		Pay It Forward
PNW Adult and Teen Challenge		Sweet Home Police Department
Creating Housing Coalition		FAC Group

Other: _____

The information which may be disclosed/exchanged is:

- Presence in the program
- Legal records; and
- Treatment records (assessment, family history, medical history, diagnosis, treatment history, and recommendations), including those from the Linn County Mental Health and Alcohol and Drug Treatment Programs
- Other: _____

This release authorizes the exchange of the aforementioned information between Linn County Adult Services Team members in order to offer the most complete and thorough services available. **It does not authorize release to any other person or agency except those agencies listed above.**

I understand that I may revoke this authorization at any time by contacting any member of the Linn County Adult Services Team and verbally informing them of my desire to revoke this authorization. Unless earlier revoked, this release and exchange shall remain in force for a period of twelve (12) months from the date of authorization.

I also understand that no one can disclose HIV information about me, except as required or permitted by federal or state law or rule, or with my written permission.

By signing this form, I am authorizing the release of protected information, as specified above, between and among the identified Linn County Adult Services Team members.

To the agency/designee receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR Part 2) and HIPAA prohibits you from making any further disclosure of it 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 or other information is not sufficient for this purpose.

_____ _____
Authorized Signature Date

_____ _____
Witness Date