**CLACKAMAS COUNTY**
**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I hereby authorize the use and disclosure of my health information as described in this authorization.

Specific person or organization (or class of persons) authorized to provide information:

- ❑ *Providence Health Plan*
- ❑ *Kaiser Permanente*
- ❑ *Flex-Plan*
- ❑ *Metropolitan Life Insurance Company*
- ❑ *Other (List Below)*
- ❑ Oregon Dental Service (ODS)
- ❑ Standard Insurance Company
- ❑ *Unum Provident (LTC)*
- ❑ *Employee Assistance Program (EAP)*

_____

_____

Specific person or organization (or class of persons) authorized to receive and use the information:

_____

_____

Specific and meaningful description of the information:

_____

_____

Specific purpose of the request:

_____

_____

I understand that a photocopy of this authorization shall be as valid as the original.

I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it.

I understand that I have the right to revoke this authorization at any time by completing the revocation section below on the original or copy of this authorization and delivering it to Clackamas County Risk & Benefits Division, 2051 Kaen Road, Oregon City, OR, 97045. I understand that the revocation is effective only after it has been received and logged by Clackamas County Risk & Benefits. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by this revocation.

Signature/Date: _____

Name (please print): _____

Address: _____

City/State/Zip: _____

Daytime Telephone Number(s): _____

**REVOCATION OF AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I hereby revoke the above authorization to use and disclose my health information as described above.

Signature/Date: _____

Received and recorded by Clackamas County Risk & Benefits Division:

Signature/Date: _____