HEALTH & HUMAN SERVICES
DEVELOPMENTAL DISABILITIES SERVICES

Instructions for applying for an individual who is an adult (ages 18 and older)

If you have any questions while completing the forms please contact the Lane County Developmental Disabilities Services Office:

Phone: 541-682-6564 Email: DDSIntake@lanecountyor.gov

Mailing address: Lane County Developmental Disabilities Services,
125 E 8th Avenue, Eugene OR 97401

The forms that are included on this webpage are the basic intake packet forms. Additional release forms may be required depending the information that is reported on the application. If additional release forms are needed they will be sent to the applicant after an application is received by our office.

Please complete and submit the following forms to begin the application process:

- Intake Application (Request for Eligibility Determination): Fill out as best as possible. The applicant will need to sign/date page 7.
    - If the applicant has a court appointed legal guardian the legal guardian will need to sign the application-we will need a copy of the court order showing the applicant has a court appointed legal guardian.
- If the applicant does not have any current providers please list the last known/seen providers-this includes any previous primary care physicians, the last high school/district attended, counselors, etc.
- Interagency Release of Information Form: Please complete this form so our office can request records needed to complete a determination. The applicant's information will go in the top section (name and DOB) and the applicant will need to write their initials on the 'starred' spaces, in each 'starred' box and sign/date the signature line at the bottom of the form.
    - If the applicant has a legal guardian the legal guardian will need to initial the spaces/boxes and sign/date the form.
- CDRC/OHSU Release: If the applicant has ever been seen at CDRC or OHSU they will need to write their initials on the 'starred' spaces and sign/date the signature line.
    - If they have a legal guardian the legal guardian will need to initial and sign/date.
- HIPPA Privacy: Please review and keep. We will only communicate with the agencies/providers/individuals you authorize our office to communicate with on the release.

Once an application packet is received by our office we will request records from the agencies/providers authorized on the release form. Once all records have been obtained we will contact the parent/guardian.

The process can take 90 days. If you would like an update regarding an application status please contact the intake/eligibility team and an update will be provided.

Office of Developmental Disability Services
Request for Eligibility Determination

DHS | Oregon Department of Human Services
INTELLECTUAL/DEVELOPMENTAL DISABILITIES

For CDDP office use only

Date received	CDDP receiving form	☐ Initial application ☐ Reapplication
Title XIX Medicaid (OSIPM or MAGI) ☐ Yes ☐ No	OHP number or OHP referral date	Prime number

Applicant information (*please print*)

Last name	First name	Middle initial	Gender

Social security number	Birthdate	Birthplace	Marital status

Current address	City	State	ZIP
Mailing address (*if different*)	City	State	ZIP
Primary phone number	Email address (*optional*)		

Primary contact / Custodial parent / Guardian (*if applicable*)

Name	Relationship (*e.g., custodial parent; guardian*)		
Address	City	State	ZIP
Primary phone number	Email address (*optional*)		

Does the applicant have a court-appointed guardian?	☐ Yes ☐ No
Appointed guardian's name, address, & phone number (*note if same as above*)	
Does the applicant have a health care representative? ORS 127.505	☐ Yes ☐ No
Health care representative's name, address, & phone number (*note if same as above*)	

Referral to CDDP

Name & title of individual who referred applicant	Phone number
Has the applicant ever received, or applied for, services from a disability-related program in Oregon or any State outside of Oregon?	☐ Yes ☐ No

Please list Oregon County or other State(s)	

Applicant's preferred communication format (OAR 943-070-0040)	
In what language do you want us to speak with you?	
In what language do you want us to write to you?	
Do you need an interpreter (*including sign language*)?	☐ Yes ☐ No
Other communication needs:	

Applicant's ethnicity (OAR 943-070-0030)

Ethnicity (*Select as many boxes that apply*)

☐ Hispanic/Latino
- ☐ Cuban
- ☐ Mexican
- ☐ Puerto Rican
- ☐ South or Central American
- ☐ Other

☐ Non-Hispanic

☐ Unknown

☐ Other: _____

☐ Decline to answer

Applicant's race (OAR 943-070-0030)

Race (*Select as many boxes that apply*)

☐ American Indian or Alaska Native
- ☐ Alaska Native
- ☐ American Indian
- ☐ Canadian Inuit, Metis or First Nation
- ☐ Indigenous Mexican, Central American, or South American
- ☐ Other American Indian

☐ Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

☐ White
- ☐ Eastern European
- ☐ Middle Eastern
- ☐ Northern African
- ☐ Slavic
- ☐ Western European
- ☐ Other White

☐ African American or Black
- ☐ African
- ☐ African American
- ☐ Caribbean
- ☐ Other Black

☐ Native Hawaiian or Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

☐ Other: _____

☐ Unknown

		☐ Decline to answer

Developmental disabilities

Describe your disability and the age at which it was first observed

Intellectual disability

Observed or diagnosed conditions	If diagnosed, list provider and date
☐ Intellectual Disability	
☐ Global Developmental Delay	
☐ Delayed milestones	

Other developmental disability

Observed or diagnosed conditions	If diagnosed, list provider and date
☐ Autism Spectrum Disorder	
☐ Cerebral Palsy	
☐ Down Syndrome	
☐ Epilepsy	
☐ Prenatal exposure to drugs, alcohol, or other toxin(s)	
☐ Tourette's Disorder	
☐ Acquired/Traumatic Brain Injury	
☐ _____	

Other conditions

Observed or diagnosed conditions	If diagnosed, list provider and date
☐ Attention-Deficit/Hyperactivity Disorder	
☐ Depressive Disorder	
☐ Language Disorder	
☐ Bipolar or Personality Disorder	
☐ Posttraumatic Stress Disorder	
☐ Specific Learning Disorder	
☐ Substance-Related Disorder	
☐ _____	

☐ _____	
☐ _____	

Medical Providers

Primary care physician or clinic	Location	Phone number
Dentist or clinic	Location	Phone number
Preferred hospital	Location	Phone number

Disability evaluations

Please list professionals who have evaluated your disabilities. Include psychologists, neuropsychologists, psychiatrists, neurologists, developmental pediatricians, geneticists, and mental health providers. For example, list professionals you have seen for an IQ test, psychological evaluation, medical or genetic evaluation of your disability, or mental health assessment.

Date	Name of professional or clinic	Type of evaluation
Location (*provide address if known*)		Phone number
Date	Name of professional or clinic	Type of evaluation
Location (*provide address if known*)		Phone number
Date	Name of professional or clinic	Type of evaluation
Location (*provide address if known*)		Phone number
Date	Name of professional or clinic	Type of evaluation
Location (*provide address if known*)		Phone number

Have you ever been admitted to a treatment center or hospital for psychiatric or medical treatment?	☐ Yes ☐ No

Date	Name and location of facility or hospital name

Other service agencies (*examples include: Child Welfare, Self-Sufficiency, Vocational Rehabilitation, Mental Health*)

Start/end date	Agency/provider location	Contact's name

Start/end date	Agency/provider location	Contact's name
Start/end date	Agency/provider location	Contact's name

Medical insurance

Applicant's health insurance

☐ Private Health Insurance Carrier _____	☐ Oregon Health Plan OHP/Medicaid # _____	☐ Medicare Plan # _____
☐ I do not currently have health insurance.		

Eligibility for certain developmental disability services is dependent on your eligibility for Medicaid. If you have not yet applied, talk with the CDDP about how to apply.

Have you applied for medical assistance?	☐ Yes ☐ No

Sources of applicant's personal income

Applicant's personal income (check all that apply; do not include other household income)

☐ Employment	☐ Temporary Assistance for Needy Families (TANF)
☐ Trust fund(s)	☐ Private disability benefits
☐ Child support for applicant	☐ Adoption or guardianship assistance
☐ Veteran's benefits	☐ No income
☐ Other: _____	☐ Other: _____

Social security

Individuals with disabilities may qualify for one of two federal disability programs: Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). The Social Security Administration (SSA) manages these programs.

Have you applied for Social Security benefits?	☐ Yes ☐ No	Date of application
Do you currently receive Social Security benefits?	☐ Yes ☐ No	Start date
☐ Supplemental Security Income (SSI)	Amount	
☐ Social Security Disability Insurance (SSDI)	Amount	

Have you ever lost SSI due to earnings, receiving a Social Security benefit from a parent or a Cost of Living Allowance increase?	☐ Yes ☐ No

If you have not applied for SSI/SSDI benefits, you can learn more about social security benefits on the Social Security Website. Contact your local SSA office to apply.

These resources may be helpful:

- Understanding SSI: http://www.socialsecurity.gov/ssi/text-income-ussi.htm
- SSI Payment Amounts: http://www.ssa.gov/oact/cola/SSI.html

Educational history

Name of current school or last school attended	Start date	End date

City and state

Name of former school	Start date	End date

City and state

Have you ever received special education services at any school (*e.g., early intervention, IEP, or 504 plan*)?	☐ Yes _____
Did you graduate from high school?	☐ Yes ☐ No
If yes, what type of diploma did you receive (*or do you expect to receive*)?	☐ Regular ☐ GED ☐ Unknown ☐ Modified ☐ Certificate

Legal history

Do you have a criminal record or juvenile court record?	☐ Yes ☐ No

State and county of offense	Nature of offense

Parole/Probation officer	Phone number

Other information

Citizenship / non-citizen status

Applicants are required to provide satisfactory documentary evidence of citizenship, non-citizen national status, or non-qualified citizen status, as required by 42 CFR § 435.406, ORS 411.402 and 411.404, and OAR 411-320-0080.

Your application is not complete until you provide satisfactory documentary evidence as defined in 42 CFR § 435.407. Individuals declaring U.S. citizenship and in one of the following groups are exempt from providing evidence: individuals enrolled in Medicare; individuals receiving Supplemental Security Income, individuals receiving Social Security Disability Insurance, and individuals who are in foster care and assisted under Title IV-B or Title IV-E of the Social Security Act.

Are you a citizen or national of the United States? If yes, skip to next section.	☐ Yes ☐ No
If not a citizen, what date did you enter the United States?	
Are you a lawful permanent resident of the United States?	☐ Yes ☐ No
If not a citizen or LPR, what is your immigration status?	

Why we need your social security number

Federal laws, 42 USC 1320b-7(a)&(b), 42 CFR 435.910, 42 CFR 435.920, and 42 CFR 457.340(b), as well as OAR 461-120-0210, require applicants to provide DHS/OHA a SSN on applications for medical benefits, except as provided in OAR 461-120-0210.

DHS and OHA will use your SSN to help decide if you are eligible for benefits. DHS and OHA may use your SSN to match the information on your application with records provided to, or created by, other state and federal programs and agencies, such as the IRS, Medicaid, Social Security and Employment Department.

DHS and OHA may also use your SSN, at the request of funding agencies, to prepare aggregate data or reports about the programs you apply for and receive benefits from. Specifically, DHS and OHA may use or disclose your SSN to: operate the program you apply for or receive benefits from; conduct quality assessment and improvement activities; verify the correct amount of payments and conduct business with providers; and recover overpaid benefits.

Notification of eligibility decision

If you would like a copy of the CDDP's eligibility decision notice sent to anyone besides yourself, you must provide the name and address of the person. The CDDP must have a written authorization in order to release information and to send a notice to anyone other than the applicant or legal guardian.

Name	Relationship to applicant (*e.g., guardian, representative*)		
Address	**City**	**State**	**ZIP**

Signature

By signing below, I agree that the information contained in this application is true and correct, whether given by me or a representative. I also confirm that I have received and reviewed the notice of rights on the following page.

Signature	Date

Print name

Relationship

☐ Self (*adult applicant*)	☐ Adult's court-appointed guardian
☐ Minor's custodial parent or legal guardian	☐ _____

Notice of rights

- You are requesting services from the Oregon developmental disability system. Participation is voluntary; you may withdraw this request at any time.
- The Department of Human Services (DHS) does not discriminate. DHS serves every applicant that qualifies for services, and DHS will not treat any applicant differently because of age, race, gender, color, national origin, religion, political beliefs, disability or sexual orientation. If you believe DHS treated you unfairly, you may file a complaint with the Governor's Advocacy Office (1-800-442-5238).
- The CDDP and DHS will protect your information and records in accordance with the privacy and security polices of DHS, ORS 179.505 and ORS 179.507. The CDDP needs your authorization to request and release records related to your disability.
- Intake is complete when you sign and submit this form to the CDDP ***and*** sign authorizations for the CDDP to obtain the records that you do not provide. The CDDP will collaborate with you to assemble a complete application for services within 90 days. The CDDP may contact you to request an extension of the decision timeline beyond 90 days, if the CDDP needs more documents to make an eligibility decision. If the CDDP needs more information to determine the existence of a developmental disability, the CDDP may ask you to attend a diagnostic evaluation, in accordance with ORS 410.060 and 427.105.
- The CDDP must receive a completed application before making an eligibility decision. A completed application includes this form, as well as documents and records necessary to make an eligibility decision. When the CDDP receives all

the documents related to your disability (as described in OAR 411-320-0080(1)), the CDDP will send you a written decision notice. Intake and complete application are defined in OAR 411-320-0020.

- The CDDP's written decision notice will contain a notice of hearing rights. If you disagree with the CDDP's decision, you may request a contested case hearing, as described in ORS Chapter 183 and OAR 411-318-0025.
- You may request a contested case hearing by filling out an Administrative Hearing Request Form (SDS 0443DD), or by making a verbal request for a hearing to a CDDP or DHS employee. DHS must receive a hearing request within 90 days of the notice of eligibility decision.
- You may appoint another person to represent you or request a hearing on your behalf, including legal counsel or a relative, friend, or other spokesman. You may identify your representative when you request a hearing.

AUTHORIZATION FOR INTERAGENCY RELEASE OF CONFIDENTIAL INFORMATION

To Our Clients: We can serve you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to release information about your situation.

Legal Name Last :	First:	Mi:	Date of Birth:

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **initials** *in the applicable space next to the type of information.*

n/a HIV/AIDS information *** _____ Mental health information**

*** Genetic testing information** *** _____ Drug/alcohol diagnosis, treatment or referral information**

I authorize the following individuals or agencies to provide information to and/or receive information from:

Initial	Individuals or Agencies
*	Lane County Developmental Disabilities
*	Current or Last High School/District Attended:
*	Primary Care Physician:
*	Medical Specialist:
*	Mental/Behavioral Health Provider:
*	Other:
*	Psychologist (TBD by Lane CDDP if evaluation is needed):

Including records of:

Family History	_____	Yes	_____	No	Employment / Unemployment	_____	Yes	_____	No
Educational Reports	_____	Yes	_____	No	Alcohol/Drug Treatment	_____	Yes	_____	No
Mental Health Services	_____	Yes	_____	No	Medical/Psychiatric Treatment	_____	Yes	_____	No

Alcohol/drug, mental health and medical records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral, progress reports, psychological and IQ testing.
Other, as listed:_____

Purpose: The information received will be used to evaluate your situation and to plan for and coordinate services for you and your family, or for other purposes as specified: **To aide in determining your eligibility for DD Services**

This authorization is good for one year or until: **Revoke**

I can cancel this authorization for release at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I understand that health information that is disclosed may potentially be re-disclosed and if it is re-disclosed to a person/ provider that is not covered by state or federal privacy laws this information is no longer protected by those laws. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

_____
Full Legal Signature of Client/Applicant or Parent/Guardian Date ☐ Client ☐ Parent ☐ Guardian

_____
Full Signature of Case Manager Date

Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence
3181 SW Sam Jackson Park Rd,
Mail Code: OP17A
Portland, OR 97239-3098
(503) 494-8521, Fax (503) 494-6970

ACCOUNT NO.
MED. REC. NO
NAME
BIRTHDATE
Patient Identification

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

*ALL SECTIONS OF THIS FORM **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.*

I authorize: CDRC/OHSU
(Name of person / entity/ facility disclosing information)

3181 SW Sam Jackson Park Rd (Address of person / entity) Portland (City) OR (State) 97239 (Zip Code)

to use and disclose a ☑ Paper copy **and/or** ☑ Electronic copy of the specific health information described below regarding:

(Name of individual)

consisting of: *(see back side for definitions)* ✓ Physician reports ____ X-rays ____ Labs ____ ED
____ Billing ____ Other, specify ____

✓ If outpatient practice/clinic records are needed, please specify the practice(s)/clinic(s) *(see back side for practice/clinic list)* CDRC-Eugene

to: Lane County DD Services
(Name of recipient)

125 E 8th Avenue (Address of recipient) Eugene (City) OR (State) 97401 (Zip Code)

for the purpose of: *(Describe each purpose of disclosure)* ✓ Continued Care ____ Legal ✓ Disability
____ School Entry ____ Other, specify ____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my ***initials*** in the applicable space next to the type of information.

n/a HIV/AIDS information
★ ____ Mental health information
★ ____ Genetic testing information
★ ____ Drug/alcohol diagnosis, treatment, or referral information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Medical Correspondence, Health Information Services, OP17A, OHSU 3181 SW Sam Jackson Park Rd. Portland, OR 97239-3098, and state that you are revoking this authorization

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.

This authorization expires one year from the date of signing unless revoked or otherwise specified below:

(enter alternative expiration date or event) ____

★ By: ____ ★ Date: ____
(Signature of individual or personal representative)

Description of personal representative's authority: ____

MR1470

LANE COUNTY HEALTH & HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
NOTICE OF PRIVACY PRACTICES

Effective Date: June 30, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Lane County Health & Human Services (HHS) provides many types of services, such as public health, mental health, and drug and alcohol services. HHS staff must collect information about you to provide these services. HHS knows that information we collect about you and your health is private. HHS is required to protect this information by Federal and State law. We call this information "protected health information (PHI)."

The Notice of Privacy Practices will tell you how HHS may use or disclose information about you. Not all situations will be described. HHS is required to give you a notice of our privacy practices about the information we collect and keep about you. HHS is required to follow the terms of the notice currently in effect.

HHS May Use and Disclose Information Without Your Authorization

• **For Treatment.** HHS may use or disclose information with health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment. ***There are exceptions to this for some A&D, Mental Health, and HIV services.***
• **To Coordinate Care.** HHS is now part of a state certified Coordinated Care Organization (CCO). If you are an Oregon Health Plan Member, HHS may use or disclose your health information to other providers in the CCO who are involved in your care for the purpose of providing whole-person care.
• **For Payment.** HHS may use or disclose information to get payment or to pay for the health care services you receive. For example, HHS may provide PHI to bill your health plan for health care provided to you.
• **For Health Care Operations.** HHS may use or disclose information in order to manage its programs and activities. For example, HHS may use PHI to review the quality of services you receive.
• **To Business Associates.** If the information is necessary for them to perform functions on behalf of HHS or for medical reviews, legal services, audits or management activities related to HIPAA compliance. They are obligated to protect the privacy of your information.
• **For Health Oversight Activities.** HHS may use or disclose information during inspections or investigations of our services.
• **As Required by Law and For Law Enforcement.** HHS will use and disclose information when required or permitted by federal or state law or by a court order.
• **For Abuse Reports and Investigations.** HHS is required by law to receive and investigate reports of abuse.
• **To Avoid Harm.** HHS may disclose PHI to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

Uses and Disclosures in Special Situations

We may use or disclose your PHI in the situations described below unless you notify us in writing that you would like us not to. See the information below under "Your PHI Privacy Rights" for information about how to request limitations.

• **Appointments and Other Health Information.** HHS may send you reminders for medical care or checkups.
• **For Public Health Activities.** HHS is the public health agency that keeps and updates vital records, such as births and deaths, and tracks some diseases.
• **For Government Programs.** HHS may use and disclose information for public benefits under other government programs. For example, HHS may disclose information for the determination of Supplemental Security Income (SSI) benefits.
• **For Research.** HHS uses information for studies and to develop reports. These reports do not identify specific people.
• **Individuals Involved in Your Care.** Unless you object, HHS may disclose to a member of your family, a relative, or a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree to such a disclosure, such as with a medical emergency, we may disclose such information as necessary if we determine that it is your best interest based on our professional judgment.

Other Uses and Disclosures Require Your Written Authorization

For other situations, HHS will ask for your written authorization before using or disclosing information, including for marketing purposes or any situation that constitutes sale of PHI. You may cancel this authorization at any time in writing. HHS cannot take back any uses or disclosures already made with your authorization.

• **Other Laws Protect PHI.** Many HHS programs have other laws for the use and disclosure of information about you. For example, except as noted above for coordinating care, you must give your written authorization for HHS to use and disclose your mental health, HIV, or alcohol and drug treatment records.

Your PHI Privacy Rights

When information is maintained by HHS as a public health agency, the public health records are governed by other State and Federal laws and are not subject to the rights described below.

• **Right to See and Get Copies of Your Records.** In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

• **Right to Request a Correction or Update of Your Records.** You may ask HHS to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request.

• **Right to Get a List of Disclosures.** You have the right to ask HHS for a list of disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization.

• **Right to Request Limits on Uses or Disclosures of PHI.** You have the right to ask that HHS limit how your information is used or disclosed. You must make the request in writing and tell HHS what information you want to limit and to whom you want the limits to apply. HHS is not required to agree to the restriction, in most cases. If requested and consistent with law, HHS shall agree not to send health information to your health plan for payment of health care operating purposes if the information concerns a health care item or service for which you have paid HHS out of pocket in full. You can request that the restrictions be terminated in writing or verbally.

• **Right to Choose How We Communicate with You.** You have the right to ask that HHS share information with you in a certain way or in a certain place. For example, you may ask HHS to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.

• **Right to File a Complaint.** You have the right to file a complaint if you do not agree with how HHS has used or disclosed information about you.

• **Right to Get a Paper Copy of this Notice**. You have the right to ask for a paper copy of this notice at any time.

• **Right to Be Notified of Breach.** You have a right to be notified if we (or a business associate) discover a breach of your unsecured health information.

How to contact HHS to Review, Correct, or Limit Your Protected Health Information (PHI)

You may contact your local HHS office or the HHS Privacy Officer at the address listed at the end of this notice to:

- Ask to look at or copy your records
- Ask to limit how information about you is used or disclosed
- Ask to cancel an authorization
- Ask to correct or change your records
- Ask for a list of the times HHS disclosed information about you

HHS may deny your request to look at, copy or change your records. If HHS denies your request, HHS will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. You will also receive information about how to file a complaint with HHS or with the U.S. Department of Health and Human Services, Office for Civil Rights.

How to File a Complaint or Report a Problem

You may contact any of the people listed below if you want to file a complaint or to report a problem with how HHS has used or disclosed information about you. HHS cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

Lane County Health & Human Services, H&HS HIPAA Concerns
151 W. 7th Ave. #520, Eugene, OR 97401
Phone: 541-682-8710 Fax: 541-682-3804 Email: HHSHIPAAConcerns@co.lane.or.us

US Department of Health & Human Services, Office for Civil Rights
Medical Privacy, Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, D.C. 20201
Phone: 866-627-7748 TTY: 886-788-4989 Email: www.hhs.gov/ocr

For More Information

If you have any questions about this notice or need more information, please contact the program below:

Lane County Health & Human Services, H&HS HIPAA Concerns
151 W. 7th Ave. #520, Eugene, OR 97401
Phone: 541-682-8710 Fax: 541-682-3804 Email: HHSHIPAAConcerns@co.lane.or.us

In the future, HHS may change its Notice of Privacy Practices. Any changes will apply to information HHS already has, as well as any information HHS receives in the future. A copy of the new notice will be posted at each HHS site and facility and provided as required by law. You may ask for a copy of the current notice anytime you visit an HHS facility, or get it on-line at www.lanecounty.org/hhs