

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip _____ Phone _____
Disclose Records From: Check one: <input type="checkbox"/> One Community Health <input type="checkbox"/> Other (Specify)	Name _____ Phone _____ Address _____ Fax _____ City _____ State _____ Zip _____
Disclose Records To: Check one: <input type="checkbox"/> Self <input type="checkbox"/> Other	Name _____ Address _____ City _____ State _____ Zip _____ Phone Number _____ Fax Number _____ E-mail _____
Method/Format: (How and when do you want the information?)	Check one: <input type="checkbox"/> Secure E-mail Link <input type="checkbox"/> Mail (<input type="checkbox"/> Paper or <input type="checkbox"/> CD) <input type="checkbox"/> Pick-Up <input type="checkbox"/> Fax NOTE: Most requests are processed within 30 days <input type="checkbox"/> Urgent Request. Records needed by: _____
Purpose:	<input type="checkbox"/> Personal Copy <input type="checkbox"/> Insurance <input type="checkbox"/> Other _____ <input type="checkbox"/> Care Continuity <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Legal/Attorney
Information to be Disclosed:	Date(s) of Service: From _____ / _____ / _____ To _____ / _____ / _____ (Unless otherwise indicated, records from the past 12 months will be released) <input type="checkbox"/> Well Child Checks <input type="checkbox"/> Immunization/Allergy Record <input type="checkbox"/> History & Physical Exam <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Medication List <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> X-ray/Imaging <input type="checkbox"/> Visit Notes <input type="checkbox"/> Other Records (Specify record type(s)) _____ <input type="checkbox"/> All Clinical Records <input type="checkbox"/> Billing Records
Special Authorization Section	The following types of records will <u>not</u> be disclosed unless checked: <input type="checkbox"/> HIV Testing and Results <input type="checkbox"/> Sexually-Transmitted Disease <input type="checkbox"/> Genetic Records Behavioral/Mental Health Records <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Attendance <input type="checkbox"/> Discharge Plan <input type="checkbox"/> Other (specify): Alcohol, Drug, or Substance Use Records <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Attendance <input type="checkbox"/> Discharge Plan <input type="checkbox"/> Other (specify):
<p>•You are not required to sign this Authorization. The care provided to you by One Community Health will not be affected if you do not sign.</p> <p>•You may revoke/cancel this Authorization at any time by writing to One Community Health's Privacy Officer at 849 Pacific Ave. Hood River, OR 97031. Revoking/canceling this Authorization will not affect any use or disclosure of your health information that has already taken place. This authorization will expire on the following date or event: _____ (if none specified, in 12 months), unless you revoke/cancel this Authorization sooner.</p> <p>•Once your health information is disclosed, it may no longer be protected by federal and state privacy laws and re-disclosed to others. However, certain types of sensitive information (such as HIV/AIDS information, behavioral health information, genetic testing information and substance use information) may be protected by laws that do not allow re-disclosure.</p> <p>•This Authorization must be signed and dated by the patient or the person authorized by law to serve as the patient's personal representative. A personal representative who is the patient's legal guardian or custodian or has health care power of attorney for the patient must provide legal documentation demonstrating his/her authority.</p> <p>•OCH may charge a reasonable cost-based fee for copies of records in compliance with state and federal laws.</p>	
I have reviewed and understand this Authorization to Disclose Protected Health Information Signature _____ Date _____ Print Name _____ Relationship to Patient _____	TO BE COMPLETED BY STAFF: Initials of person disclosing information _____ Date _____ Photo ID/Signature verified _____ Medical Record Number _____ Patient Encounter Number _____