



Patient	Patient Name: _____ Birth Date: _____ Ph. #: _____ SSN: _____ Address: _____		
From / To	I authorize the use and/or disclosure of the health information described below for the above-named patient by the following entities: <i>(Complete addresses required in order to process request)</i>		
	Information is to be released FROM: _____ _____	Information is to be disclosed TO: _____ _____	
	Please specify the hospital, clinic, or practice holding the records. _____ _____		
Purpose	For the purpose(s) of: <input type="checkbox"/> At the request of the patient or legal/personal representative <input type="checkbox"/> Other purposes (specify each purpose): _____		
Info to be Disclosed	Description of nature of information to be used and/or disclosed: (initial all that apply)		
	<input type="checkbox"/> Discharge summaries <input type="checkbox"/> Pathology reports <input type="checkbox"/> History & Physical exams <input type="checkbox"/> Radiology/imaging reports <input type="checkbox"/> Consultations <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Operative reports <input type="checkbox"/> EKG reports <input type="checkbox"/> Physician progress notes <input type="checkbox"/> Emergency Dept. record <input type="checkbox"/> Nursing notes <input type="checkbox"/> Medication records <input type="checkbox"/> Clinician office notes <input type="checkbox"/> Billing statements <input type="checkbox"/> Other information (specify): _____	Specially Protected Information: <input type="checkbox"/> Mental health treatment records <input type="checkbox"/> Drug/Alcohol abuse diagnosis, treatment, and referral records <input type="checkbox"/> Information re: HIV/AIDS/Sexually transmitted diseases <input type="checkbox"/> Information re: Genetic testing (Oregon) <input type="checkbox"/> Records for the following dates or treatment: _____	
Notices	<input type="checkbox"/> All health records from the above-named entity (Excludes above Specially Protected information unless indicated by initials) 1. I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, Sexually Transmitted Diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment, or referral information, Federal law and regulation including 42 CFR Part 2 and 445 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information. 2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else. 3. I may revoke this authorization at any time by notifying the Health Information Management/Medical Records Department of the above-named entity on its designated form. However, any such revocation will not apply to any activity undertaken based on this authorization. PeaceHealth's Joint Notice of Privacy Practices also describes how to revoke this authorization. 4. I received a copy of this authorization. I may inspect or request copies of information disclosed by this authorization.		
Dates	Unless revoked, this authorization is valid for 90 days from the signature date below or for the following time period. Beginning date: _____ Ending (expiration) date: _____ (In Washington state, expiration date can be no later than 1 year after this authorization is signed if disclosure is to employer or financial institution.)		
Signature	SIGNATURE: I have read this authorization, and I understand it. _____ Signature of Patient or personal representative Relationship to patient Date *If the patient's personal representative, you may be required to provide appropriate documentation to demonstrate authority to act on behalf of the patient (Examples of documentation include Power of Attorney, Death Certificate, Court order)		
For PeaceHealth Use Only	Date Received: _____ MRUN # _____ Acct # _____ <input type="checkbox"/> Identity and authority verified <input type="checkbox"/> Fees explained if needed <input type="checkbox"/> Records sent by _____ Date/Time: _____		

Please don't write in box:



Release of Information SYS1020 (11/30/21)

Authorization