PeaceHealth

Authorization to Use and Disclose Health Information

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: (Complete addresses required in order to process request)

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:

❑ At the request of the patient or legal/personal representative

❑ Other purposes (specify each purpose): _____

Info to be Disclosed

Description of nature of information to be used and/or disclosed: (initial all that apply)

_____ Discharge summaries
_____ History & Physical exams
_____ Consultations
_____ Operative reports
_____ Physician progress notes
_____ Nursing notes
_____ Clinician office notes
_____ Pathology reports
_____ Radiology/imaging reports
_____ Laboratory reports
_____ EKG reports
_____ Emergency Dept. record
_____ Medication records
_____ Billing statements
_____ Other information (specify)
_____
_____ Records for the following dates or treatment:
_____

<u>Specially Protected Information</u>:

_____ Mental health treatment records
_____ Drug/Alcohol abuse diagnosis, treatment, & referral records
_____ Information re: HIV/AIDS/Sexually transmitted diseases
_____ Information re: Genetic testing (Oregon)

_____ All health records from the above-named entity (Excludes above Specially Protected information unless indicated by initials)

Please don't write in box:  Release of Information

White Copy: Med. Record, Yellow Copy: Patient

Authorization SYS1020-V (11/30/21)

Notices	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 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 # _____ ❑ Identity and authority verified ❑ Fees explained if needed ❑ Records sent by _____ Date/Time: _____

Please don't write in box:

Release of Information SYS1020-V (11/30/21)

White Copy: Med. Record, Yellow Copy: Patient

Authorization