From: Check the appropriate box and fill in the name of the entity that is to disclose the information. If PeaceHealth is the disclosing entity, a facility address stamp may be used.

Patient: Enter as much identifying information as possible on the patient whose information is to be used or disclosed.

To: Check the appropriate box and fill in the name of the entity that is to receive and/or use the information. If PeaceHealth is the recipient, a facility address stamp may be used.

Purpose: Check the appropriate box. If other than at the patient's or representative's request, describe how the information is to be used.

Info to be Disclosed:

- Select type(s) of information to be disclosed by marking specific check boxes.
- You may specify information for a specific date range or information related to treatment for a specific condition.
- You may specify that all records from the specified entity be disclosed.
- Specially protected information will not be disclosed unless specifically selected.

Dates: If a date range is specified, the disclosing entity will make disclosures only between the dates specified. Otherwise, the authorization will expire no later than 90 days after the form is signed.

Signature: Authorization must be signed by the patient or the patient's legal representative. If not signed by the patient, describe the signer's relationship to the patient. Signature must be dated.

PeaceHealth

Authorization to Use and Disclose Health Information

Patient

Patient Name: _____ Medical Record #: _____

Birth Date: _____ Ph. #: _____ SSN: _____

From

I authorize: ☐ PeaceHealth ☐ This other Healthcare Entity (name/address of disclosing entity):

(Facility address stamp) *OR* _____

_____

_____

To use and/or disclose a copy of the health information described below for the above-named patient.

Health information is to be received and used by:

☐ PeaceHealth ☐ This other Entity (name/address of recipient):

(Facility address stamp) *OR* _____

_____

_____

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

☐ Discharge summaries	☐ Pathology reports	Specially Protected Information:
☐ History & physical exams	☐ Radiology & imaging reports	☐ Mental health treatment records
☐ Consultations	☐ Laboratory reports	☐ Drug/Alcohol abuse diagnosis, treatment, & referral records
☐ Operative reports	☐ EKG Reports	☐ Information re: HIV / AIDS / Sexually transmitted diseases
☐ Physician progress notes	☐ Emergency Dept. records	☐ Information re: Genetic testing (Oregon)
☐ Nursing notes	☐ Medication records	
☐ Clinician office notes	☐ Billing statements	

☐ Records for the following dates or treatment: _____

☐ Other records (specify): _____

☐ All health records from the above named entity (Excludes the above Specially Protected Information unless box(es) checked)

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 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, the expiration date can be no later than 90 days after this authorization is signed)

Signature

SIGNATURE: I have read this authorization, and I understand it.

_____ _____

Signature of Patient or legal/personal representative Date

Relationship to patient: _____

Date Released: _____ Acct. #: _____ ☐ Identity and authority verified ☐ Fees explained if needed

☐ Records sent by: _____

by: Med. Record; Yellow Copy: Patient (12/03)