PeaceHealth

Authorization to Use and Disclose Health Information

Patient

Patient Name: _____

Birth Date:_____ Phone #: _____ SSN: _____

From/To

I authorize the use and/or disclosure of the health information described below for the above-named patient by the following entities:

Information is to be released FROM:	***Information is to be disclosed TO:***
_____	_____
_____	_____
_____	_____

Please specify the hospital, clinic, or practice holding the records (see back side for listing):

_____

_____

_____

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: (initial all that apply)

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

Specially Protected Information:

__ 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 the above Specially Protected Information unless indicated by initials)

Please don't write in box: * B 0 F *

White Copy: Med. Record, Yellow Copy: Patient

HIM Internal

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 45 CFR parts 160 and 164 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 Date Time

Relationship to patient:_____

*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 _____ MRN # _____ Acct # _____ ☐ Identity and authority verified

☐ Fees explained if needed ☐ Records sent by _____ Date/Time _____

PeaceHealth

Hospitals and Clinics
Health Information Management
1115 SE 164th Ave., Dept. #336
Vancouver, WA 98683

DEFINITION OF REPORTS

- Physician reports include Discharge Summary, Discharge Instructions, History and Physical Exams, Office Visits, Acute Care Visits, any procedures or operations.
- X-rays include X-ray reports, ultrasound, MRI, CT scans, any special Imaging reports
- Labs - all laboratory test results
- Billing - clinic billing information
- Immunizations - all immunization records
- Other - specify information not listed

LOCATION OF CARE

- Alaska area
- Bellingham area
- Longview area
- Vancouver area
- Oregon area

OUTPATIENT PRACTICES/CLINICS:

Allergy and Immunology
Anesthesiology
Anticoagulation
Audiology
Bariatric (Weight Loss) Surgery
Behavioral Health
Cancer Care
Cardiology
Center for Senior Health
Dermatology
Diabetes Wellness
Endocrinology
Family Medicine
Gastroenterology
General Surgery
Hematology and Oncology
Infectious Disease
Integrative Medicine Clinic
Internal Medicine
Musculoskeletal Clinic
Nephrology
Neurology
Nurse Midwife Services
Obstetrics and Gynecology (OB-GYN)
Occupational Health
Ophthalmology
Orthopedic Surgery
Otolaryngology (Ear, Nose and Throat)
Pediatric Cardiology
Pediatric Surgery
Pediatrics
Physical Rehabilitation Medicine
Podiatry
Psychiatry
Pulmonology
Rehabilitation
Sleep Medicine
Thoracic and Vascular Surgery
Trauma Surgery
Urgent Care
Urology
Walk-in-clinic
Women's Health