PeaceHealth *Authorization to Use and Disclose Health Information*

Patient

Patient Name: ______________________________

Birth Date: ______________ Ph. #: ______________ 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	_____ Pathology reports	**Specially Protected Information:**
_____ History & physical exams	_____ Radiology & imaging reports	_____ Mental health treatment records
_____ Consultations	_____ Laboratory reports	_____ Drug/Alcohol abuse diagnosis, treatment, and 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 information (specify): ______________

____

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

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 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 ______________ MRN # ______________ Acct # ______________ ☐ Identity and authority verified

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

Please don't write in box: * BOF * HIM Internal

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