



AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Patient's Information

| | | | | |
|---------------------------|--|--------------------|--|-------------|
| Patient Last Name | | Patient First Name | | Middle Name |
| Nickname/Maiden Name | | Birth Date | Telephone: Okay to leave detailed message? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Patient's Mailing Address | | | | |

Healthcare Provider to Release Information:

| | | |
|---------|-------|-----|
| Name | | |
| Address | | |
| City | State | Zip |
| Phone | Fax | |

Person or Agency to Receive Information:

| | | |
|---------|-------|-----|
| Name | | |
| Address | | |
| City | State | Zip |
| Phone | Fax | |

Requesters information

Purpose of release: _____
If such information exists, I authorize the disclosure of the entire medical record **or** the following specific documents, dates of service, and/or information about the following injury/illness/disease: _____

The following items **must be initialed** to be released:

Patient should initial if they would like this information to be released

- _____ HIV-positive test results and HIV diagnosis
- _____ Mental health information and/or records (Oregon only)
- _____ Genetic testing information and/or records (Oregon only)
- _____ Other sexually transmitted diseases (Washington only)
- _____ Drug/alcohol diagnosis, treatment or referral information. Per Federal regulations, describe how much and what kind of information is to be disclosed: _____

Federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so. The only circumstance when refusal to sign means the patient will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire on the earlier of 1 year from the date of signing or on **You can leave this blank and the authorization expires in 1 year. Or you can add a future date for the authorization to expire.**

I am requesting the following records in electronic format:
 Discharge Instructions Available Electronic Medical Record

Mary A. Smith

Signature of Patient or Patient's Legal Representative

Date

Print Name (If other than the patient, proof of authority is required.)

Relationship to Patient

If this is signed by an authorization representative, valid supporting documentation must accompany this authorization.

