3600

PROVIDENCE Health & Services

OREGON REGION

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. I authorize Providence Health System (PHS) to use and disclose a copy of the specific health information described below regarding: (**Name of individual - Please print**)_____

   Date of Birth (_ _/_ _/_ _) **Contact Phone Number**: _____

   To the following: (Name of Recipient(s))_____

   Recipient(s) Address: _____City:_____

   State: _____ ZIP: _____ Phone: _____Fax: _____

2. I am requesting records from the following Providence Facility(s):

Hospital		**Physician Clinic**
__Providence Portland	__Providence Milwaukie	List Clinic(s) _____
__Providence St. Vincent	__Providence Newberg	
__Providence Hood River	__Providence Medford	_____
__Providence Seaside	__Providence Willamette Falls	
__Other: _____		_____

3. For the range of dates from: (_ _/_ _/_ _) to (_ _/ _ _/_ _)
4. The specific health care information pertaining to: _____
5. The purpose of the use/disclosure is for: _____
6. There maybe a fee associated with this request.
7. If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my ***initials*** in the applicable space next to the type of information.

   _____HIV/AIDS information _____ Mental health information

   _____Genetic testing information _____ Drug/alcohol diagnosis, treatment, or referral information

8. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.
9. You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization means you 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 needed to make that disclosure.
10. You may revoke this authorization in writing at any time. If you revoke this authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when PHS has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.
    To revoke this authorization, please send a written statement to: ATTN:

    AND state that you are revoking this authorization. Name:

    Address: City: State: ZIP:
11. Providence Health and Services no longer prints or releases patient Social Security Numbers unless required for insurance billing. However, social security numbers may be included in patient records that are more than a few years old. The records you are authorizing to be released may include your social security number.
12. I have read this authorization and I understand it. Unless revoked, this authorization expires: (specify either date or event)_____

By:_____ _____

Individual/Personal Representative **Date**

Personal Representative's Name (please print): _____