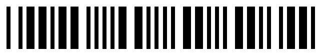


3600

PROVIDENCE Health & Services

# AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I understand the following:

- There may be a fee associated with this request.
- 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.
- I do not need to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.
- I have the right to receive a copy of this signed authorization.
- I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when PH&S has taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

To revoke this authorization, send a written statement that you are revoking this authorization along with a copy of this authorization to:

Centralized Release of Information Department

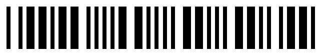
4400 NE Halsey Street, Building 1, Suite 286

Portland, OR 97213

Phone (855) 234-2491 Fax: (855)234-2493

Providence Health & Services no longer prints or releases patient social security numbers unless required for 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 included your social security number.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.



3600

PROVIDENCE Health & Services

# AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

For What States:

☐ Alaska ☐ California ☐ Montana ☐ Oregon ☐ Washington

I authorize Providence Health & Services to use and disclose a copy of the specific health information described below regarding:

Patient's Name: ____________ DOB: ____________

Patient/Representative Name: ____________ Phone: ____________

To be disclosed to: (Name of Recipient(s)): ____________

Recipient's Address: ____________

City: ____________ State: ____________ Zip: ____________

Phone: ____________ Fax: ____________

I am requesting records from the following facility(s):

| Hospitals Name (List)/Phone Number | Clinics Name (List)/Phone Number |
|---|---|
| | |
| | |

For the range of dates from: ____________ to: ____________

For records related to the following diagnosis or injury: ____________

| Information to be disclosed: | |
|---|---|
| ☐ History & Physical | ☐ Discharge Summary |
| ☐ Operative Report | ☐ Emergency Department Report |
| ☐ Diagnostic Reports (lab, x-ray, EKG, etc.) | ☐ Entire Chart |
| ☐ Other (specify): ____________ | |

For the purpose of: ____________

If the information to be disclosed contains any of the 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 testing/treatment ____Mental Health specific visits

____Genetic Testing ____Drug/Alcohol specific visits

Unless revoked, this authorization expires in 180 days or on this Date: ____________

Sign Here: ______________________________ Date: ____________

(Print form and sign by hand)

Print Name: ____________