



Authorization to Use and Disclose Health Information

(Sample only-This form should be ordered from Stores/Materials Management. It is a 2-part NCR form)

Patient Name: _____

Date of Birth: _____ Medical Record #: _____

I authorize: PeaceHealth or Other entity (name of disclosing party): _____

(address) _____

to use and/or disclose a copy of the health information described below for the above-named patient name.

Health information is to be received and used by:

PeaceHealth or Other entity (name and institutional affiliation of recipient): _____

(address) _____

For the purpose(s) of:

At the request of the individual (e.g., patient)

Other purposes (specify each purpose): _____

Description or nature of information to be used and/or disclosed:

- Discharge summaries Operative reports All hospital records
 History & physical exams Radiology & imaging reports Clinician office notes
 Consultations Laboratory reports Billing statements
 Pathology reports Most recent 2 years
 Records for the following dates or treatment: _____
 Other (specify): _____

I authorize the information listed below to be used, disclosed, or received by placing my initials next to the information:

- _____ Mental health _____ Drug and/or alcohol abuse diagnosis, treatment, or referral
_____ Genetic testing (Oregon) _____ HIV / AIDS / Sexually transmitted diseases

1. If the recipient of the information is not a health plan or provider covered by federal or state privacy laws, then the information used, disclosed, and received under this authorization may be subject to redisclosure and no longer protected by those laws.

2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, payment for services, enrollment in a health plan, or eligibility for benefits, except if 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 are solely for the purpose of providing health information to someone else.

3. I may revoke this authorization at any time by notifying the Health Information Management/Medical Records Department on the designated form, except to the extent that action has been taken in reliance upon this authorization. PeaceHealth's Joint Notice of Privacy Practices also describes how this authorization may be revoked.

4. Unless revoked, this authorization is limited to the following time period (first and last dates):

Commencing: Date of authorization Other (specify): _____

Ending (expiration date): _____ (In Washington, the expiration date can be no longer than 90 days after this authorization is signed.)

5. I received a copy of this authorization. I may inspect or request copies of information disclosed by this authorization.

SIGNATURE: I have read this authorization, and I understand it.

_____ Date: _____
patient or legal/personal representative

If not signed by the patient, description of legal/personal representative's authority: _____

Identification: _____

For PeaceHealth Use Only:

Date Received: _____ Verification of Identity and Authority Fees explained if needed

Records have been sent by: _____ Date: _____