525 SE WASHINGTON ST.
PO BOX 378
DALLAS, OR 97338
(503) 623-8301 FAX (503) 623-7337

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Identification Verified
If picked up in Person:
☐ Picture ID ____________________
☐ DL# ________________________

Patient's Name: ____
Date of Birth: ______________ Soc. Sec. #: ________________________
Patient Phone #: ____
Medical Record #: ____
Date(s) of Service: ____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. **I hereby authorize:** ____
(fill in name of individual/facility/agency)
____
(fill in address)
____
(city, state, zip code)

3. **To provide medical and/or psychiatric information to:**
____
(fill in name of individual /facility/agency)
____
(fill in address)
____
(city, state, zip code)

4. Indicate the information and time period that is to be disclosed: Time period:_____________ to _______________

☐ History/Physical
☐ Lab Report(s)
☐ Consultation(s)
☐ Operative Report(s)
☐ Radiology Report(s)
☐ Radiology Film(s)
☐ Discharge Summary
☐ Emergency and Urgent Care Records
☐ Pathology
☐ Diagnostic Test(s)
☐ Other ____

5. 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 only if I place my ***initals*** 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

6. This information for which I am authorizing disclosure will be used for the following purpose:
☐ Personal records ☐ Patient care ☐ On site review ☐ Legal ☐ Other (please describe) ____________________

7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

8. This authorization will expire (insert date or event)*: ______________________________________
*If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

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RELEASE OF PROTECTED HEALTH INFORMATION

10. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

11. I understand that I will receive a copy of this signed authorization.

12. I understand that authorizing the use or disclosure of the information identified above is voluntary. West Valley Hospital will not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.

_______________________________________ _______________________

Signature of patient or legal representative Date

_______________________________________ _______________________

Signature of witness Date

Note: Incomplete Authorizations will not be processed and will be returned to you for completion.