Authorization for Use and Disclosure of Protected Health Information

PATIENT IDENTIFICATION:

Name: _____ Date of Birth: ___/___/___

Address: _____

_____

Social Security #: _____ Telephone: (____) _____

DATES OF HEALTH CARE TO BE RELEASED:

From (date) _____

To (date) _____

PERSON AUTHORIZED TO RECEIVE THE INFORMATION:

Name: _____

Address: _____

_____

Telephone: (____) _____ Fax: (____) _____

PURPOSE OF REQUEST:

☐ Treatment or consultation

☐ At the request of the patient

☐ Billing or claims payment

☐ Other: _____

TYPE OF INFORMATION TO BE RELEASED:

_____ Emergency room report	_____ Laboratory test reports	_____ Radiology Imaging reports
_____ Operative report	_____ History & Physical exam	_____ Radiology Imaging
_____ Discharge Summary	_____ Consultation reports	_____ Itemized bill

Other: _____

Time Limit & Right to Revoke Authorization Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Willamette Valley Medical Center. Unless revoked, this authorization will expire in 180 days or on the following date or event: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release. **Initial YES** _____ **Initial NO** _____

I understand that if my medical or billing record contains information in reference to HIV / AIDS (Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. **Initial YES** _____ **Initial NO** _____

Re-disclosure I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. 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.

Signature of Patient or Personal Representative Who May Request Disclosure I understand that Willamette Valley Medical Center may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize Willamette Valley Medical Center to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Relationship if not the patient: _____

Identity of requesto verified by whom: _____

_____ Photo ID

_____ Matching signatures

_____ Other: _____

Identity of recipient verified by whom: _____

_____ Photo ID

_____ Matching signatures

_____ Other: _____

Signature of Recipient: _____

Willamette Valley Medical Center
Health Information Management
2700 SE Stratus Avenue **Ph. (503) 435-6415**
McMinnville, OR 97128 **Fax (503) 435-6517**

* R O I *

RELEASE OF INFORMATION AUTHORIZATION FORM

INSTRUCTIONS FOR COMPLETING RELEASE OF INFORMATION FORM

1. Patient Identification- This is a required field. This section is for patient information. Please fill out completely.

2. Person Authorized to Receive Information- This is a required field. This area is for whom you want to receive the information.

3. Dates of health care to be released- This is a required field. This section must be completed from and to. This area may be as general as month/year to month/year or year-to-year but must be completed with a date.

4. Purpose of Request- This is a required field. There is an "other" field if none of the choices apply.

5. Type of Information to be Released- This is a required field. Please indicate what type of information you want to be released. There is an "other" line for any information that is not listed.

6. Time Limit & Right to Revoke Authorization- This is an area that you can complete a date or event for expiration of the authorization. If you do not complete a date or event, it will automatically expire in 180 days from the date signed.

7. Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release- If this area does not apply you do not have to complete it. (However, If there is ANY mention of this in the record, it will not be released)
IF YOU PUT A CHECK ON "YES" OR "NO", YOU MUST INITIAL THE RESPONSE OR THE ENTIRE AUTHORIZATION IS NO LONGER VALID.

8. Re-disclosure & Ability Statement- These are required statements but no response is necessary.

9. Signature of Patient or Personal Representative Who May Request Disclose- This area must be signed by the patient or proof of authorization to sign must be attached. (i.e.: Death Certificate with signer's name on it as Next of Kin, Power of Attorney for health care with physician's statement of patient's inability to sign, court order giving guardianship)

10. Relationship (if not the patient)- This is a required field for the relationship of the signer (i.e.: POA, parent (if the patient is under 18). A stepmother, grandmother, etc CANNOT sign an authorization for medical records unless they are court ordered as the guardian.

11. Date- This is a required field. It is the date the patient signs the form.

INFORMATION BELOW THE RELATIONSHIP AND DATE LINE ARE FOR OFFICE USE ONLY