AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Name & address of health care provider, clinic or hospital:

Name of provider, clinic or hospital

Street Address

City, State, Zip

To use/disclose medical information to:

Legacy Emanuel Pediatric Development & Rehabilitation

Name

2801 N Gantenbein

Street Address

Portland, OR 97227

City, State, Zip

Patient Name:		Date(s) of Service:	Purpose:
Social Security Number:	Date of Birth:	Other Names Used:	Patient's or Personal Representative's Phone Number:

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:

Specify below:

_____ Clinic records
_____ Transcribed hospital reports
_____ Progress notes
_____ Emergency and urgent care records
_____ Photographs and Videotapes
_____ Demographic sheet/face sheet
_____ Please send the entire medical record (all information) to the above named recipient.
_____ Other:_____

_____ Dental records
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Billing statements

* The following items must be initialed to be included in the use and/or disclosure of other medical information:

_____ *HIV-positive test results and HIV diagnosis
_____ *Mental health information and/or records (Oregon ONLY)
_____ *Genetic testing information and/or records (Oregon ONLY)
_____ *Other sexually transmitted diseases (Washington ONLY)
_____ *Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe: _____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

I understand that the person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I 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 necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire on the earlier of 1 year from the date of signing or on_____

Signature of Patient or Patient's Legal Representative

Date

Print Patient's Name or Name of Legal Representative (if applicable)

Relationship to Patient

☐ Patient's or Legal Representative's Personal Identification Verified. Records Copied by: _____