Providence | Health System

A caring difference you can feel
OREGON REGION
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. **Patient** (Please print)_____ **Date of Birth** (_ _/_ _/_ _)
   I authorize Providence Health System to disclose a copy of my Protected Health Information to:
   Recipient: _____
   Address: _____
   City: _____ State: _____ ZIP: _____
2. **The specific health care information to be used/disclosed consists of:**
   ☐ The past 2 years of pertinent information, ☐ For dates of service from (_ _/_ _/_ _) to (_ _/_ _/_ _)
   ☐ Discharge Summary ☐ History ☐ Consult ☐ Operative Report ☐ Pathology ☐ Lab ☐ X-Ray Reports
   ☐ ECG/EEG/ECHO ☐ Other (specify): _____
3. **The purpose of the use/disclosure is for:** ☐ Insurance ☐ Disability ☐ Legal_____
   ☐ Other_____
4. 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 if **I place my *initials* in the applicable space** next to the type of information.
   _____ Genetic testing information _____ Mental health information _____ HIV/AIDS information
   _____ Drug/alcohol diagnosis, treatment, or referral information
5. I understand that 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.
6. You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization means you 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 needed to make that disclosure.
7. You may revoke this authorization in writing at any time. If you revoke this authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when PHS has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

   To revoke this authorization, please send a written statement AND state that you are revoking this authorization to:
   Providence Medical Group-Newberg Family Medicine
   308 N. Villa Rd. Suite 114
   Newberg, OR 97132
8. I have read this authorization and I understand it. Unless revoked, this authorization expires:
   180 days from date of signing.
9. **Signature:** _____ _____
   Patient or Personal Representative **Date**
   Personal Representative's Name (please print): _____
   Description of personal representative's authority: _____

Distribution: ▫ Medical Record/Chart (Original) ▫ Patient/Authorized Representative

Revised Date: March 26, 2004 Form PHS-OR 240

The authorization must be filled out completely and specifically or we may not be able to release records.