Authorization for Disclosure of PHI

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

Name of Patient: ____Date of Birth: ______________________

USE & DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the release of my records from: ____

Address: ____Fax:______________________

My records should be sent/delivered to: ____

Address: ____ Fax: _____________________

- o All health information pertaining to my medical history, mental or physical condition and treatment received OR
- o Only the following records or types of health information (including any dates): _________________________
  ____

☐ Mail records ($5.00 fee) ☐ Fax ☐ Patient pick up

I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information[1] (A separate authorization is required to authorize the disclosure or use of psychotherapy notes).
☐ HIV test results
☐ Alcohol/drug treatment information

PURPOSE

Purpose of requested use or disclosure: ☐ Continuing Care ☐ Transfer of Care ☐ Other ___________________
____

EXPIRATION

This Authorization expires one year from execution or (insert date): ____

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may revoke this authorization any time, but I must do so in writing and submit it to the following address:

2660 NE Highway 20, Suite 610-26 Bend, OR 97701

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization. I have a right to receive a copy of this authorization.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA). If this box is checked, the Requestor will receive compensation for the use or disclosure of my information.[4]

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Name of Patient: ____ Date of Birth: ________________

SIGNATURE (SIGNATURE SECTION MUST BE COMPLETED)

Date: ____

Time: ____ AM / PM

Signature: ____

(Circle One: Patient / Representative / Spouse / Financially Responsible Party)

Witness: ____ Date: _________________

[1] If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the Physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

[2] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of authorization as follows: (i) to conduct research-related treatment (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[3] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.

[4] The requestor is to complete this section of the form.