Authorization for Use and Disclosure of Protected Health Information

PATIENT IDENTIFICATION:

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

Address: _____

_____

Social Security #: _____ Telephone: (____) _____

DATES OF TREATMENT TO BE RELEASED:

From (date): _____

To (date): _____

RECIPIENT 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:

- ☐ Chart notes
- ☐ Procedure report
- ☐ Immunization record
- ☐ Prescription/Medication records
- ☐ History & Physical exam
- ☐ Consultation reports
- ☐ Laboratory test reports
- ☐ Radiology reports

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/Clinics. Unless revoked, this authorization will expire in 180 days or on the following date or event: _____.

Release of Specially Protected Health Information

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 Clinics 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 Clinics to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Relationship if not the patient: _____

Identity of requestor verified by whom: _____

_____Photo ID

_____Matching signatures

_____Other: _____

Identity of recipient verified by whom: _____

_____Photo ID

_____Matching signatures

_____Other: _____

Signature of Recipient: _____

McMinnville Internal Medicine

Willamette Valley Clinics

254 NE Norton Lane

McMinnville, OR 97128

503-472-9002 Phone

503-474-2649 Fax