ONE COMMUNITY HEALTH
541-386-3680
www.onecommunityhealth.org

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Phone _____

Disclose Records From:

Check one:

☐ One Community Health
☐ Other (Specify)

Name _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip _____

Disclose Records To:

Check one:

☐ Self
☐ Other

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____ E-mail _____

Method/Format:

(How and when do you want the information?)

Check one:

☐Secure E-mail Link ☐ Mail (☐ Paper or ☐ CD) ☐ Pick-Up ☐Fax ☐ MyChart

NOTE: Most requests are processed within 30 days ☐ Urgent Request. Records needed by: _____

Purpose:

☐ Personal Copy
☐ Care Continuity
☐ Transfer of Care
☐ Insurance
☐ Worker's Compensation
☐ Legal/Attorney
☐ Other _____

Information to be Disclosed:

Date(s) of Service: From ____/____/____ To ____/____/____

(Unless otherwise indicated, records from the past 12 months will be released)

☐ Well Child Checks
☐ History & Physical Exam
☐ Medication List
☐ X-ray/Imaging
☐ Other Records (Specify record types(s)) _____
☐ Immunization/Allergy Record
☐ Pathology Reports
☐ Laboratory Reports
☐ Visit Notes

☐ All Clinical Records ☐ Billing Records

Special Authorization Section

The following types of records will not be disclosed unless checked:

☐ HIV Testing and Results
☐ Sexually-Transmitted Disease
☐ Genetic Records

Behavioral/Mental Health Records
☐ Assessment ☐ Treatment Plan ☐ Attendance ☐ Discharge Plan ☐ Other (specify): _____

Alcohol, Drug, or Substance Use Records
☐ Assessment ☐ Treatment Plan ☐ Attendance ☐ Discharge Plan ☐ Other (specify): _____

•You are not required to sign this Authorization. The care provided to you by One Community Health will not be affected if you do not sign.
•You may revoke/cancel this Authorization at any time by writing to One Community Health's Privacy Officer at 849 Pacific Ave. Hood River, OR 97031. Revoking/canceling this Authorization will not affect any use or disclosure of your health information that has already taken place. This authorization will expire on the following date or event: _____ (if none specified, in 12 months), unless you revoke/cancel this Authorization sooner.
•Once your health information is disclosed, it may no longer be protected by federal and state privacy laws and re-disclosed to others. However, certain types of sensitive information (such as HIV/AIDS information, behavioral health information, genetic testing information and substance use information) may be protected by laws that do not allow re-disclosure.
•This Authorization must be signed and dated by the patient or the person authorized by law to serve as the patient's personal representative. A personal representative who is the patient's legal guardian or custodian or has health care power of attorney for the patient must provide legal documentation demonstrating his/her authority.
•OCH may charge a reasonable cost-based fee for copies of records in compliance with state and federal laws.

I have reviewed and understand this Authorization to Disclose Protected Health Information

_____ _____
Signature Date

_____ _____
Print Name Relationship to Patient

TO BE COMPLETED BY STAFF:

Initials of person disclosing information Date _____

Photo ID/Signature verified _____

Medical Record Number _____

Patient Encounter Number _____