SOUTH HILYARD CLINIC
AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Patient Name: ____ Date of Birth: ______________________

Address: ____

Please RELEASE information FROM:

____
Physician or Clinic Name

____
Street Address

____
City/State/Zip

____
Phone Number

____
Fax Number

Please RELEASE information TO:

____
Physician or Clinic Name

____
Street Address

____
City/State/Zip

____
Phone Number

____
Fax Number

Unless otherwise indicated this release is for the purpose of: ____ **Consent to communicate**, ____ **Transfer of care**, ____ **Consult**, ____ **Other** ____.

Please send the past 2 years of clinical notes and lab reports, the past 5 years of imaging, diagnostic tests and operative reports, and all immunization records. Additionally, I especially request records regarding:

____

I have reviewed and understand this authorization.

______________________________	______________________________	__________
Signature of patient or legally responsible person*	**Relationship to patient**	**Date**

*In the event this Authorization is signed by a legal representative other than parents of a minor child, documentation of legal authority must be attached. (i.e. Health Care Power of Attorney, or Court appointed Health Care Representative.)

Unless otherwise revoked, this authorization will expire on the following date:

Effective Date: ________________________ Expiration Date: __________________________
If I fail to specify an expiration date, this authorization will expire 1 year from the date signed.

The following must be INITIALED by the requestor to be included in the use and/or disclosure:

_____ *HIV/AIDS related information and/or records

_____ Mental Health Information

_____ Genetic Testing information

_____ **Drug/alcohol treatment

* This information may not be re-disclosed without the specific written authorization of the individual, except where authorized by law.
** Federal regulation (in 42 CFR Part 2) requires a description of how much and what kind of information will be disclosed.

In accordance with Oregon State Law (OAR333-12-270 Sub 8) you are required to state the purpose of release for HIV/HTLV test results/records: ____ At my request, ____ Other____.

These results may be released from this date _____________ until ______________ (please enter expiration date).

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

1) Creating health information about you to be disclosed to a third party; or
2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to the Privacy officer at 3525 Hilyard St. Eugene OR 97405 that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer can be protected by federal law.
Please allow 30 days for requested information to be transferred.