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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Name of Patient: _____ **Date of Birth:** _____

I hereby authorize information to be released:

From: Individual or Facility _____

Phone: _____ Fax: _____

To: Individual or Facility _____

Phone: _____ Fax: _____

If copy is for patient, please check (✓) one:

☐ Portal (No fee)

☐ Mail to: (Fee applies)

_____

_____

The purpose of this disclosure is: ☐ Continuation of Care ☐ Copy for Patient ☐ Other: _____

Indicate type of information to be released by checking (✓) the spaces below. I specifically authorize the use or disclosure of the following health information and/or records, if such information exists:

____ Exchange of Information ONLY
____ Laboratory Reports
____ Diagnostic Imaging Reports
____ Billing Statements
____ ONA Chart Notes From _____To_____
____ All ONA Records for the last 2 years
____ Entire ONA Record
____ Other: _____

I understand that I may revoke this authorization at any time by giving a ***written*** notice, unless action requested has already taken place.
*PLEASE NOTE: Expiration date is **365 days** from date of signature below or **until**: _____.

***** The following items *must* be ***initialed*** to be included with other documents:

_____ ***Genetic testing** information and/or records
_____ ***Psychotherapy notes** (Neuropsychological Testing Reports)
_____ *HIV / AIDS related health information and/or records
_____ *Mental health information and/or records
_____ *Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)
For the time following time period: _____ For the following treatment: _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand Oregon Law ORS 192.563 states that the person(s) I am authorizing to disclose my information may receive compensation from myself or the outside entity (either directly or indirectly).

_____ _____ _____
Signature of Patient or Patient's Legal Representative | Relationship of Legal Representative to Patient | Date