

Westover Heights Clinic

2330 NW Flanders, Suite 207 • Portland, OR 97210 • Phone: 503-226-6678 • Fax: 503-226-4307

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

◆ PLEASE PRINT CLEARLY ◆ ONLY PROPERLY COMPLETED FORMS WILL BE PROCESSED ◆

Patient Name: _____

Patient Address / City / State / Zip: _____

Patient Date of Birth: _____ Telephone: _____

Fill in Only LEFT Box or RIGHT Box

I authorize Westover Heights Clinic TO GIVE INFORMATION TO:	↔	I authorize Westover Heights Clinic TO GET INFORMATION FROM:
Name: _____		Name: _____
Facility: _____		Facility: _____
Address: _____		Address: _____
City/State/Zip: _____		City/State/Zip: _____
Telephone: _____		Telephone: _____
Fax: _____		Fax: _____

Information to be disclosed is indicated by the checked box(s) below:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Medical Summary | <input type="checkbox"/> ECG Testing Results | <input type="checkbox"/> OTHER - Please Specify: |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Radiology (Imaging) Results | |
| <input type="checkbox"/> Problem List | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Mammography Results | |
| <input type="checkbox"/> Current Medication List | | <input type="checkbox"/> Operative Results | |
| | | | |

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that **this information will be disclosed if I place my initials in the applicable space** next to the type of information.

___ HIV/AIDS Information ___ Mental Health ___ Genetic Testing Information ___ Drugs/Alcohol Diagnosis, Treatment or Referrals

The information for which I am authorizing release will be used for:

- Coordination of Care Change of Medical Provider Personal Use Other (explain): _____

I UNDERSTAND THAT:

- Authorizing the disclosure of the health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department, Westover Heights Clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless I specify a shorter period or revoke, this authorization will expire 12 months (one year) from the date of signature below.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

AUTHORIZATION / SIGNATURES

I have read this authorization and I understand it.

Date: _____ Patient Signature: _____

NOTE: If the patient is 13 years or younger and is not an emancipated minor, the parent or legal guardian must sign. If the patient of any age is unable to sign the authorization for any reason, a legal representative must sign.

Date: _____ Guardian/Representative Signature: _____

Relationship to Patient: _____ Printed Name: _____

COPY OF COMPLETED FORM GIVEN TO PATIENT Offered & Given Copy Declined

Revised November 9, 2012