Authorization to Use and Disclose Health Information

____ **Harney District Hospital (HDH)** **PLEASE ALLOW 5 WORKING DAYS** Burns, OR 97720
____ **HDH Family Care Clinic** Phone 541-573-8339 Fax 541-573-5192
____ **NewSun Energy and HDH Specialty Clinic**

Patient

Patient Name: _____ **Date of Birth:** _____
Address: _____ **Phone #:** _____

From / To

I authorize the use and/or disclosure of health information described below for the above-named patient by the following entities: ***(Complete addresses required in order to process request)***

Information to be released FROM:	Information to be disclosed TO:
Name: _____	Name: _____
Address: _____	Address: _____
Phone/Fax:	Phone/Fax:

Purpose

Purpose for which disclosure is to be made *(initial all that apply)* : ____Self ____ Insurance
____Consultation ____Legal ____School/Job ____SS/Disability ____ Continuity of Care
____Other (Specify):

Info to be Disclosed

Description of nature of information to be used and/or disclosed: ***(Initial all that apply)***

___Discharge summaries
___History & Physical exams
___Consultations
___Operative Reports
___Physician progress notes
___Clinician office notes
___Immunizations
___Pathology reports
___Radiology/imaging reports
___Images on CD
___Laboratory reports
___EKG reports
___Emergency Dept. report

Specially Protected Information
___Psychiatric/Mental health records
___Drug/Alcohol abuse diagnoses, treatment, and referral records
___Information re: HIV/AIDS/STD records
___Information re: Genetic testing (Oregon)

___Other information (specify): _____
___All health records for the last 3 years from the above-named entity ***(Excludes above Specially Protected Information unless indicated by initials)***
DATES OF TREATMENT: _____

Delivery

WOULD YOU LIKE YOUR RECORDS ____ Mailed to you ____ Faxed to your physician
____ You will pick up at admitting ____ Other person you designate for pick up (Name)

Notices

1. I understand that this authorization is valid only for the specific reason for which the information was requested.
2. I understand that I have the right to withdraw this authorization at any time in writing. The revocation must be provided to Harney District Hospital Health Information Management/Medical Records Department.
3. I understand that I do not have to sign this authorization to get treatment.
4. I understand that once my health care information is disclosed as I have authorized, it could be re-Disclosed by the recipient and is no longer protected by Harney District Hospital
5. I understand that the records will be sent after they have been reviewed by Harney District Hospital
6. I understand that this authorization is valid for a period of 60 days from the date of completion.

Dates

Unless revoked, this authorization is valid for 60 days from the signature date below or for the following time period.
Beginning date: _____ Ending (expiration) date: _____

Signature

I have read this authorization, and I understand it.

_____ _____ _____
Signature of Patient or Personal Representative * Relationship to patient Date

_____ _____
Witness Signature Date

*If the patient's personal representative, you may be required to provide appropriate documentation to demonstrate authority to act on behalf of the patient (Examples: Power of Attorney, Death Certificate, Court order)

For HDH Staff Use Only

Date Received: _____ MRN# _____ Acct : _____
Identification verified: _____ Drivers License _____ Other photo ID
Records sent by: _____ Date/Time: _____