

Authorization to Use and Disclose Health Information

____ Harney District Hospital (HDH)
 ____ HDH Family Care Clinic
 ____ NewSun Energy and HDH Specialty Care Clinic

PLEASE ALLOW 5 WORKING DAYS

Burns, OR 97720
 Phone 541-573-8339 Fax 541-598-3440

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: Name: _____ Address: _____ Phone/Fax: _____	Information to be disclosed TO: Name: _____ Address: _____ Phone/Fax: _____																					
	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) <table style="width:100%; border:none;"> <tr> <td style="width:33%; border:none;"><input type="checkbox"/> Discharge summaries</td> <td style="width:33%; border:none;"><input type="checkbox"/> Pathology reports</td> <td style="width:33%; border:1px solid black; vertical-align:top;">Specially Protected Information</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> History & Physical exams</td> <td style="border:none;"><input type="checkbox"/> Radiology/imaging reports</td> <td style="border:none;"><input type="checkbox"/> Psychiatric/Mental health records</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Consultations</td> <td style="border:none;"><input type="checkbox"/> Images on CD</td> <td style="border:none;"><input type="checkbox"/> Drug/Alcohol abuse diagnoses, treatment, and referral records</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Operative Reports</td> <td style="border:none;"><input type="checkbox"/> Laboratory reports</td> <td style="border:none;"><input type="checkbox"/> Information re: HIV/AIDS/STD records</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Physician progress notes</td> <td style="border:none;"><input type="checkbox"/> EKG reports</td> <td style="border:none;"><input type="checkbox"/> Information re: Genetic testing</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Clinician office notes</td> <td style="border:none;"><input type="checkbox"/> Emergency Dept. report</td> <td style="border:none;">(Oregon)</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Immunizations</td> <td colspan="2" style="border:none;">____ Other information (specify): _____</td> </tr> </table>		<input type="checkbox"/> Discharge summaries	<input type="checkbox"/> Pathology reports	Specially Protected Information	<input type="checkbox"/> History & Physical exams	<input type="checkbox"/> Radiology/imaging reports	<input type="checkbox"/> Psychiatric/Mental health records	<input type="checkbox"/> Consultations	<input type="checkbox"/> Images on CD	<input type="checkbox"/> Drug/Alcohol abuse diagnoses, treatment, and referral records	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Laboratory reports	<input type="checkbox"/> Information re: HIV/AIDS/STD records	<input type="checkbox"/> Physician progress notes	<input type="checkbox"/> EKG reports	<input type="checkbox"/> Information re: Genetic testing	<input type="checkbox"/> Clinician office notes	<input type="checkbox"/> Emergency Dept. report	(Oregon)	<input type="checkbox"/> Immunizations	____ Other information (specify): _____	
	<input type="checkbox"/> Discharge summaries	<input type="checkbox"/> Pathology reports	Specially Protected Information																				
<input type="checkbox"/> History & Physical exams	<input type="checkbox"/> Radiology/imaging reports	<input type="checkbox"/> Psychiatric/Mental health records																					
<input type="checkbox"/> Consultations	<input type="checkbox"/> Images on CD	<input type="checkbox"/> Drug/Alcohol abuse diagnoses, treatment, and referral records																					
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Laboratory reports	<input type="checkbox"/> Information re: HIV/AIDS/STD records																					
<input type="checkbox"/> Physician progress notes	<input type="checkbox"/> EKG reports	<input type="checkbox"/> Information re: Genetic testing																					
<input type="checkbox"/> Clinician office notes	<input type="checkbox"/> Emergency Dept. report	(Oregon)																					
<input type="checkbox"/> Immunizations	____ Other information (specify): _____																						
____ All health records for the last three 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 ____ Other: _____ ____ 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 120 days from the date of completion.																						
Dates	Unless revoked, this one time authorization is valid for 120 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. <table style="width:100%; border:none;"> <tr> <td style="width:45%; border:none;">Signature of Patient or Personal Representative *</td> <td style="width:25%; border:none;">Relationship to patient</td> <td style="width:30%; border:none;">Date</td> </tr> <tr> <td style="border:none;">_____</td> <td style="border:none;">_____</td> <td style="border:none;">_____</td> </tr> <tr> <td style="border:none;">Witness Signature</td> <td colspan="2" style="border:none;">Date</td> </tr> <tr> <td style="border:none;">_____</td> <td colspan="2" style="border:none;">_____</td> </tr> </table> *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)		Signature of Patient or Personal Representative *	Relationship to patient	Date	_____	_____	_____	Witness Signature	Date		_____	_____										
Signature of Patient or Personal Representative *	Relationship to patient	Date																					
_____	_____	_____																					
Witness Signature	Date																						
_____	_____																						
For HDH Staff Use Only	Date Received: _____ MRN# _____ Acct : _____ Identification verified: ____ Drivers License ____ Other photo ID Records sent by: _____ Date/Time: _____																						