



**Oregon Health & Science University
Hospitals and Clinics
Health Information Services /
Medical Correspondence**
3181 SW Sam Jackson Park Rd,
Mail Code: OP17A
Portland, OR 97239-3098
(503) 494-8521, Fax (503) 494-6970

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
ALL SECTIONS OF THIS FORM **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize: _____
(Name of person / entity/ facility disclosing information)

(Address of person / entity) (City) (State) (Zip Code)

to use and disclose an electronic copy of the specific health information described below; unless you check here for a paper copy. This release is regarding:

(Name of individual)

consisting of: (see back side for definitions) Physician reports X-rays (please see the back side of this form for complete instructions) Labs ED Billing
 Other, specify _____

If outpatient practice/clinic records are needed, please specify the practice(s)/clinic(s) (see back side for practice/clinic list) _____

to: _____
(Name of recipient)

(Address of recipient) (City) (State) (Zip Code)

for the purpose of: (Describe each purpose of disclosure) Continued Care Legal Disability
 School Entry Other, specify _____

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 only if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information _____ Genetic testing information
_____ Mental health information _____ Drug/alcohol diagnosis, treatment, or referral information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Medical Correspondence, Health Information Services, OP17A, OHSU 3181 SW Sam Jackson Park Rd. Portland, OR 97239-3098, and state that you are revoking this authorization

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

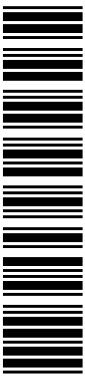
I have read this authorization and I understand it.

This authorization expires one year from the date of signing unless revoked or otherwise specified below:

(enter alternative expiration date or event) _____

By: _____ Date: _____
(Signature of individual or personal representative)

Description of personal representative's authority: _____





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Continued from page 1

Patient Identification

DEFINITION OF REPORTS:

- Physician reports include Discharge Summary, Discharge instructions, History & Physical exam, any procedures or operations
- X-rays include X-ray reports, Ultra sound, MRI, and special Imaging reports (If you are requesting for an actual image please make sure to fill out the Authorization Form MR-4775) The form may be accessed at the following web site: <http://ozone.ohsu.edu/healthsystem/HIS/mr4775.pdf>
- Labs – all laboratory test results
- ED – Emergency Department reports by physician
- Billing – Hospital and / or clinic billing information
- Immunizations – all immunization records
- Other – Specify information not listed

OHSU OUTPATIENT PRACTICES/CLINICS:

- | | |
|--|---|
| Adult Psychiatry | Infectious Disease |
| Allergy & Immunology | Intercultural Psychiatry Program |
| Anticoagulation | Internal Medicine |
| Audiology | Knight Cancer Center/Community Hematology
Oncology |
| Bone & Mineral | Lipids |
| Bone Marrow Transplant / Leukemia | Liver Transplant |
| Cardiology | Marquam Hill Internists |
| Casey Eye Institute | Nephrology & Hypertension |
| CDRC Eugene | Neurology |
| Center for Women's Health | Neurosurgery |
| Child and Adolescent Psychiatry | Oral & Maxillofacial Surgery |
| Childhood Development and Rehabilitation
(CDRC) | Orthopaedics |
| Comprehensive Pain Center | Otolaryngology |
| Dermatology | Pediatric Hematology / Oncology |
| Dermatology Surgery | Pediatric Specialties |
| Diabetes | Perinatal |
| Digestive Health | Plastic Surgery |
| Doernbecher Pediatrics - Westside | Pulmonary |
| Employee Health | Radiation Oncology |
| Endocrinology | Renal Transplant |
| Executive Health | Rheumatology |
| Family Medicine at South Waterfront | Richmond |
| Gabriel Park | Riverplace |
| Gastroenterology | Scappoose |
| General Pediatrics | Sleep Medicine |
| General Surgery | Surgical Oncology |
| GI / Hepatology | Urology |
| Health Promotion and Sports Medicine | Vascular Surgery |
| Hematology / Oncology | |