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

Patient Identification

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 _____ Radiology Report
Other, specify Clinic Records, NWRESD Report of Eye Exam

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

to: NW Regional ESD
(Name of recipient)

5825 NE Ray Circle Hillsboro OR 97124
(Address of recipient) (City) (State) (Zip Code)

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

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
_____ Mental health information
✓ Genetic testing 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:_____ Time: _____
(Signature of individual or personal representative)

Description of personal representative's authority:_____

MR1470

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

Continued from page 1

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

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