UMPQUA HEALTH

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize the following health care provider(s) to use, share and disclose medical information of the patient named below, as follows:

Health care provider who is disclosing information:

____
Name of provider, clinic or hospital

____
Street Address

____
City, State, Zip

____
Phone Fax

Person or organization who is receiving information:

____
Name (if an individual, include affiliated institution, if any)

____
Street Address

____
City, State, Zip

____
Phone Fax

Patient Name:	Date(s) of Service, if applicable:	Patient ID Number:
Date of Birth:	Other Names Used:	Patient's or Personal Representative's Phone Number:

Describe each purpose of disclosure, or indicate that the disclosure is at the request of the individual:

_____ At the request of the individual (initial in the space provided); or

____

____

By **initialing** the spaces below, I authorize the use and/or disclosure of the following:

________Entire medical record (except the Specially Protected Information identified by asterisk below)
________Partial record, including (check all that apply):

________Clinic records
________Transcribed hospital reports
________Progress notes
________Emergency and urgent care records
________Photographs and Videotapes
________Demographic sheet/face sheet
________Other: ______________________________

________Dental records
________Laboratory reports
________Pathology reports
________Diagnostic imaging reports
________Billing statements

*Specially Protected Information: Except as specifically permitted by law, the following types of information will not be disclosed unless I authorize the disclosure by **placing my initials** in the space(s) next to type of information to be disclosed:
________*HIV-positive test results and HIV diagnosis
________*Mental health information and/or records
________*Genetic testing information and/or records (Oregon ONLY)
________*Other sexually transmitted diseases (Washington ONLY)
________*Drug/alcohol diagnosis, treatment or referral information.

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I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal and state law. However, I also understand that federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. Revocation shall be sent to ___________________________________ (contact person) at ____ (address), identifying you by name and by birth date or patient identification number, and stating that you are revoking this authorization.

If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire one year from the date of signing on ______________________________, or as otherwise identified here: ____.

____	______________________________
Signature of Patient** or Patient's Legal Representative***	Date
____	______________________________
Print Name of Legal Representative (if applicable)	Relationship to Patient

**Patients of the following ages must sign this form to release their PHI to any person or facility, except when release to a parent or guardian is permitted by law or regulation:
14 years of age and above: All medical conditions (Washington); mental health and chemical dependency (Oregon)
15 years of age and above: All other medical conditions (Oregon)

***If you are not the patient's parent, please attach documentation of your authority.

☐ Legal Representative's authority to act as Representative verified

☐ Patient's or Legal Representative's Personal Identification Verified — Records Copied by: ______________________________

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