Coos Health & Wellness
Together, Inspiring Healthier Communities

Promotes and provides innovative quality health services, prevention, and education for our communities

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Per ORS 192.566

Patient's Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Number/Name City State

Telephone: _____ Date of Birth: _____

-- I Authorize the Use and Disclosure of My Protected Health Information (PHI) Described Below --

Initial box of the PHI you are requesting be used and disclosed.

INITIAL ☐ Complete Patient File

INITIAL ☐ Other (describe): _____

Authorization for Sensitive Information

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. If my records contain any such information, I authorize the use and disclosure of that information only if I place my **INITIALS** in the applicable box.

INITIAL ☐ Mental/Psychiatric health information

INITIAL ☐ Genetic testing information

INITIAL ☐ Drug/alcohol diagnosis, treatment, or referral information

INITIAL ☐ HIV/AIDS

I Authorize the following Clinic/Organization/Person to share my health records (PHI) with Coos Health & Wellness to use & disclose:

Name: _____

Address: _____

Phone: _____

INITIAL ☐ I Authorize **MUTUAL EXCHANGE** of Information between CHW and Clinic/Organization/Person specified in this ROI

Authorization Expiration* 3 years from date of release

*TERM: Unless otherwise specified/revoked, authorization expires when no longer needed by Coos Health & Wellness for treatment, payment or health care operations purposes.

PURPOSE: I authorize Coos Health & Wellness, my physician, mental health care and/or health care provider to disclose my health information during the term of this Authorization for the following specific purpose(s):

INITIAL ☐ At My Request

INITIAL ☐ Other (describe): _____

I Understand:

1. Once Coos Health & Wellness discloses my health information to the recipient as permitted by this authorization, Coos Health & Wellness cannot guarantee that the recipient will not re-disclose my health information to a third party and is no longer protected by federal health information privacy law.
2. I may revoke this authorization at any time by giving Coos Health & Wellness notice of my revocation in writing. Coos Health & Wellness will furnish me with a form to make my revocation but I do not have to use that form to make my written revocation.
3. This Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Coos Health & Wellness, my physician and/or health care provider (identified in this Authorization). My revocation of this authorization will not apply to information used and disclosed as permitted by this authorization before I give Coos Health & Wellness, my physician and/or health care provider (identified in this Authorization) written notice of my revocation.
4. Coos Health & Wellness may not condition my treatment or payment, enrollment or eligibility for benefits on whether I sign this authorization. However, if my treatment at Coos Health & Wellness is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Coos Health & Wellness may refuse to treat me if I do not sign this Authorization. If my treatment is related to my participation in a research study, I understand that Coos Health & Wellness may refuse to treat me if I do not sign this Authorization.
5. This Authorization is not valid for use or disclosure of Psychotherapy Notes, use or disclosure of Protected Health Information for Marketing purposes or for the Sale of Protected Health Information.

I may, at any time, make a written request to Coos Health & Wellness to inspect and/or obtain a copy of my health information, and that Coos Health & Wellness will, within five (5) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

I have read and understand this Authorization for the Use and Disclosure of Protected Health Information, I have had an opportunity to ask questions. I received a copy of this signed authorization.

By my signature, I hereby, knowingly and voluntarily authorize Coos Health &Wellness, my physician and/or medical provider to use and disclose my health information in the manner described.

Signature of Patient	Date

Personal Representative – If Applicable:

Signature of Personal Representative	Description of Authority to Act	Date

NOTE* If **Patient** is a **Minor** **OR** **Otherwise Unable to Sign** this Authorization
Complete Personal Representative Information Above

INTERNAL USE ONLY

____ Identity of Patient Verified ____ Personal Rep. - Identity **and Authority** to Act Verified

Signature of CH&W Staff	Name & Title	Date

PROVIDE A COPY OF SIGNED AUTHORIZATION TO CLIENT