Oregon Health & Science University
Hospitals and Clinics
Integrity Office
3181 SW Sam Jackson Park Rd
Mail Code: L106-IO
Portland, OR 97239-3098
(503) 494-0219, Fax (503) 494-4828

MR1470

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

AUTHORIZATION FOR USE OF INFORMATION BY THE OHSU/DCH FOUNDATION(S) FOR CHARITABLE GIVING

Oregon Health and Science University (OHSU) depends on private charitable giving from individuals, foundations and corporations to help it search for better ways to diagnose, prevent, treat, and cure disease, as well as to improve patient care. OHSU, through its charitable foundations, asks if I would agree to be contacted in the future for charitable giving purposes for the benefit of medical research, discovery, and patient care programs/projects. I hereby authorize OHSU, the Oregon Health and Science University Foundation (OHSUF) and/or Doernbecher Children's Hospital Foundation (DCHF) to contact me for this purpose.

I further authorize OHSU, the OHSUF and/or DCHF to use my demographic information, the name of my physician(s) and the name of the department(s) or division(s) where I was treated at OHSU to help identify me as someone who may be interested in charitable giving for certain specific programs and projects.

I understand that only my physician(s) and/or OHSUF/DCHF development personnel will use this information to contact me for charitable giving purposes, and will not knowingly disclose this information to any other person or use it for any other purpose.

Note: No personal diagnostic or medical treatment information will be used or disclosed.

I understand that I may refuse to sign this authorization form. I also understand that if I do not sign this form, my treatment will not be affected in any way. This authorization will remain in effect for ten (10) years from the date of signature, or, in the case of minors, until they reach the age of 18. To revoke this authorization, please send a written request to the address noted above.

Patient Name: _____ Date of Birth: _____

Email address: _____

I have read and understand this authorization.

_____ _____
Signature of Individual or Personal Representative Date

_____
Print Name of Individual or Personal Representative

Description of personal representative's authority: _____

_____

Detailed form information available on reverse

To return form by mail:
OHSU Health Information Management, 3181 SW Sam Jackson Park Rd, Mail Code: OP17A, Portland, OR 97239-3098

☐ **Please check the box if you wish to receive a copy of this authorization by mail.**

Frequently Asked Questions

WHAT AM I SIGNING?

By signing the authorization form, OHSU, the OHSUF and/or DCHF may tell you of or provide you with: literature that notes how you can support progress in medical treatments and discovery for the diseases or conditions that are of interest to you and your family; ways to support the work of exceptional physicians, nurses, dentists, and scientists; and invitations to future events and meetings that may include charitable giving opportunities.

WHAT AM I AUTHORIZING?

Federal law allows OHSU representatives and representatives of the OHSUF and/or DCHF to contact you to request your financial support, even without your authorization, provided we only use your demographic information and dates of health care provided to you at OHSU. However, federal law only allows "targeted" fundraising communications – information about projects that will likely be of greatest interest to you – with your written authorization. For example, if you were being treated at OHSU for diabetes, OHSU, the OHSUF and/or DCHF may want to let you know about any special programs and initiatives for that disease (such as a dedicated diabetes research unit) and about giving opportunities related to that program. In that case, your treating physician may need to be contacted so that the OHSUF and/or DCHF can obtain the necessary information to contact you.

WHY IS IT NECESSARY?

OHSU is committed to protecting the privacy of your health information. As of April 14, 2003, a federal law known as the Health Insurance Portability & Accountability Act (HIPAA) enacted special protections regarding the use and release of your health information, in addition to those protections existing under Oregon law.

WHY IS IT IMPORTANT?

OHSU is the only academic health center in Oregon. OHSU relies heavily on gifts from individuals to help it search for better ways to diagnose, prevent, treat, and cure diseases. Those patients who make gifts tell us that it gives them a tremendous sense of satisfaction knowing they are helping make progress in fighting diseases that have affected them or a family member. The decision to make a gift is entirely up to you. Signing this form does not obligate you in any way.

WHAT HEALTH INFORMATION WILL BE USED AND FOR WHAT PURPOSE?

This authorization permits OHSU staff to use and disclose the name of the physician(s) you have seen and the clinic(s) you were seen in for the purpose of sending newsletters, medical updates, invitations to community events, information about initiatives that are likely to interest you (such as programs relating to your care and treatment), and other communications that may contain fund-raising information. Please note that only OHSU, the OHSUF and/or DCHF will use this information. Patient lists are not sold, rented or traded.

Note: No personal diagnostic or medical treatment information will be used or disclosed.

HOW LONG WILL THIS AUTHORIZATION BE IN EFFECT?

This authorization will remain in effect for ten (10) years from the date of signature, or, in the case of minors, until they reach the age of 18. Once your authorization expires, we will need your signature again.

WHAT IF I DON'T WANT TO SIGN, OR LATER CHANGE MY MIND AND WANT TO REVOKE THIS AUTHORIZATION?

Signing this form is entirely voluntary. Choosing not to sign will not adversely affect your ability to receive health care services, reimbursement for services, enrollment in a health plan, or eligibility for benefits. If you change your mind at any time, you can revoke this authorization by providing a written notice of revocation to the OHSU Integrity Office at 3181 Sam Jackson Park Road, Mail Code AD140, Portland, OR 97239, or by calling (855) 257-4100, stating that you are revoking your authorization regarding fund raising. If you revoke this authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. However, any uses or disclosures already made with your permission cannot be undone.

ARE THE INDIVIDUALS WHO RECEIVE MY HEALTH INFORMATION PURSUANT TO THIS AUTHORIZATION PERMITTED TO USE OR DISCLOSE IT FOR OTHER PURPOSES?

The information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law.

QUESTIONS?

The address of OHSU's Integrity Office is 3181 Sam Jackson Park Road, Mail Code L106-IO, Portland, OR 97239. You may contact this office by phone at (503) 494-0219, toll free (855) 257-4100 or fax (503) 494-4828.