



**Oregon Health & Science University
Hospitals and Clinics**
Student Health & Wellness Center
3181 SW Sam Jackson Park Rd,
Mail Code: L587
Portland, OR 97239-3098
(503) 494-8665, Fax (503) 494-2958

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 _____ Radiology Report
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

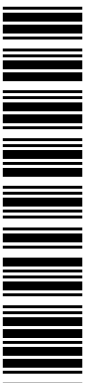
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic 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: _____ Time: _____
(Signature of individual or personal representative)

Description of personal representative's authority: _____





**Oregon Health & Science University
Hospitals and Clinics**
Student Health & Wellness Center
3181 SW Sam Jackson Park Rd,
Mail Code: L587
Portland, OR 97239-3098
(503) 494-8665, Fax (503) 494-2958

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

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	