Cancer Clinic ___ Family Clinic RHC___ Internal Medicine ___
Surgery Clinic ___ Sleep Clinic ___ Women's Clinic___

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete this form in its entirety, incomplete forms can cause a delay in processing of records

_______________________	_______________	_______________	_______________
Patient Name	Birthdate	Social Security #	Home Phone
Address	City, State, Zip Code		Work Phone

I Authorize Information to be disclosed **FROM**:

Name of Provider/Clinic	Mailing Address
City, State, Zip Code	Phone Number · Fax Number

I Authorize Information to be disclosed **TO**:

CHI-St. Anthony Clinic Name of Provider/Clinic	**2801 St. Anthony Way** Mailing Address	
Pendleton, OR 97801 City, State, Zip Code	**541-541-966-0535** Phone Number	**541-278-4597** Fax Number

Purpose of Disclosure: ____ Changing Primary Care/Clinic ____Referral Other: ____________________
Date Range: ___ Most recent 3 year history Dates of Service from: _________ to __________

Permission to fax information: ____ No ____**Yes**: I specifically consent to the faxing of my protected health information. All faxed material will contain a confidentiality statement: however; I understand confidentiality at the receiving end cannot always be guaranteed.

Type of Information to be released:

____ Medication Summary _____ Consultations _____ Laboratory Reports _____Operative Reports
____ Progress Notes _____ History & Physical _____Pathology Reports _____ X-ray Reports

This area MUST be initialed

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by Federal/State Law. By Initialing, I authorize the release of the following protected or sensitive information:
____ Drug Abuse Diagnosis/Treatment ____ Mental Health Treatment
____ Alcoholism Diagnosis/Treatment ____AIDS/STD test results & related information.

Your health care and payment for that health care cannot be conditioned upon receipt of this signed authorization unless your health care or treatment is for the purpose of:

1. Creating health information about you to disclose to a third party; or
2. For the purpose of research.

You have the right to *revoke this authorization* at any time, provided you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosers already made with your permission. To revoke this authorization, please send a written statement to *CHI-St. Anthony Hospital 2801 St. Anthony Way, Pendleton, OR 97801* that identifies the date you signed the authorization, the recipient of the information identified in this authorization, and the state that you are revoking authorization.

- ***Note to recipient: Due to computer storage space, please do not fax anything over 150 pages at one time. Please mail records larger than 150 pages or fax excess pages separately.***

This authorization will expire 180 days from the date of signing, or the end of the reasonable period needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this authorization. I also understand that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

______________________	______________________	____________
Signature of Individual	Relationship	Date

STAFF ONLY: Received by: ______________________________Date: _____________