St. Anthony Hospital
2801 St. Anthony Way
Pendleton, Oregon 97801
P) 541-966-2438
F) 541-966-0519

CommonSpirit

Authorization For Use or Disclosure of/Access to Protected Health Information

I, _____, **[Print Name of Individual (i.e., patient, resident or client)]** hereby authorize **St. Anthony Hospital –Medical Records** to use and disclose the protected health information as described below for the following patient:

Patient Name: _____ DOB: _____

Street Address: _____Phone:_____

City: _____ State: _____ Zip Code: _____

I authorize the following person(s) or organization to receive the information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

The following individually identifiable health information may be used and/or disclosed:

(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request.*)

Check (✓) all that apply:

- ☐ Abstract (Includes[1])
- ☐ Discharge Summary /Final Diagnosis[1]
- ☐ History and Physical Records[1]
- ☐ Consultation Reports[1]
- ☐ Operations and Procedures[1]
- ☐ Results of Diagnostic Testing[1]
- ☐ Emergency Room Records
- ☐ Lab Reports
- ☐ Radiology (for example: X-Ray) Reports
- ☐ Other Diagnostic Reports
- ☐ Diagnostic Images (Prepped by Radiology Dept)
- ☐ Immunization (shot) Record
- ☐ Physical Therapy Notes
- ☐ Physician Notes
- ☐ Medication List
- ☐ Itemized Bill

☐ Other*: _____

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Dates of treatment to be released: From:_____ To:_____

Reason or purpose for the use and/or disclosure of the information:
_____

I request the form of release of information be ____ Electronic (Portal) ____ Paper (U.S. Mail or pick up)
____ Other (USB, etc...**)_____ ____ Electronic (Secure Email)
**Device must be provided by the facility

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Prohibition on Conditioning of Authorization: The healthcare provider will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire 1 year from the date signed unless the facility receives a Revocation as outlined below.

Revocation: I understand that I may revoke this authorization at any time by notifying the facility in writing by sending a letter to the CHI Entity specified on this release or completing the Revocation of

Authorization form. I understand that if I revoke this authorization, it will not affect any actions that were taken before the revocation letter was received. I understand that the facility cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

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SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE **DATE (Required)**

_____

Printed name of individual's personal representative, if applicable:

_____

Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):

_____

(Please include supporting documentation such as Power of Attorney documents, or other documents establishing status as the personal representative, when applicable.)