OREGON HEALTH & SCIENCE UNIVERSITY

OHSU

MR1470

OHSU Strategic Communications
3181 S.W. Sam Jackson Park Road
Mail Code: L217
Portland, OR 97239-3098
Phone: 503 494-8231
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PRINT CLEAR

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

*All sections below **must** be completed or the authorization will not be accepted.* ***Page 1 of 1.***

I authorize OHSU to use and disclose a copy of the specific health information described below regarding:

Name of individual: _____

Address: _____

Phone number: _____ E-mail address: _____

My information that may be used and disclosed includes:

❑ My name ❑ My age ❑ Photo, video or recording of me ❑ City, county or state of residence

❑ Information about my medical history, including injuries, diseases, treatments ❑ Other information that may identify me

The purpose of releasing the above information may be one or more of the following uses and disclosures:

❑ Media request ❑ OHSU, OHSU Foundation or Doernbecher Foundation fundraising campaign or activities

❑ OHSU, OHSU Foundation or Doernbecher Foundation communications or marketing print, broadcast or electronic messages (i.e., brochure, flier, poster, newsletter, magazine, report or social media such as Twitter and Facebook)

❑ Other: _____

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 _____ Mental health information

_____ Genetic testing 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: Med. Correspondence, Health Information Services, OP17A, OHSU, 3181 S.W. Sam Jackson Park Road, 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 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 five (5) years from the date of signing unless revoked or otherwise specified below:

Enter alternative expiration date or event: _____

Signature: _____ Date/time: _____

(Signature of individual or personal representative)

Description of personal representative's authority: _____

Authorization requested by (OHSU employee — printed name): _____