# Authorization for Use or Disclosure of Protected Health Information

Patient's Name: _____ Date of Birth: _____

Address: _____ City, State, Zip Code: _____

Primary Phone: _____ Email: _____

**As indicated, I authorize my protected health information to be released from:**

- ☐ Oregon Specialty Group (all service lines)
- ☐ Oregon Specialty Group Service Line (circle):

Oncology Rheumatology Infectious Disease Specialty Infusion

- ☐ Other: Name of facility: _____
  - Address: _____
  - Phone: _____
  - Fax: _____
  - E-mail: _____

**As indicated, I authorize my protected health information to be released to:**

- ☐ Self
- ☐ Oregon Specialty Group
- ☐ Other:
  - Name of facility: _____
  - Address: _____
  - Phone: _____
  - Fax: _____
  - E-mail: _____

**Type of information to be released:**

- ☐ Chart Notes
- ☐ Operative Reports
- ☐ Medication Records
- ☐ Laboratory Reports
- ☐ Imaging Reports
- ☐ Designated Record Set (all medical and billing records)
- ☐ Other: _____

**Information to be released/obtained from treatment dates:**

From _____ to _____
*(MM/DD/YYYY)* *(MM/DD/YYYY)*

**Reason for request:**

- ☐ Personal Use
- ☐ Continuing Medical Care
- ☐ Workers' Compensation
- ☐ Other: _____

**Method in which you wish to receive records:**

__Paper Copy __Patient Portal __Fax
__Email (*Encrypted*) __Other:_____

**Method of delivery:**

__ Mail __ Portal __ Pick up at _____
__ Electronic *(Clinic Location)*

**FOR OFFICE USE:**

Records prepared by: _____

Method sent: _____

Date: _____

If the information to be used/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 used or disclosed if I place my initials in the applicable space next to the type of information:

_____ Drug/Alcohol diagnosis, treatment, or referral information _____ HIV / AIDS information

_____ Mental health information _____ Genetic testing information

I understand that: I may revoke this authorization at any time by notifying Oregon Specialty Group at the address below, in writing, and this authorization will cease to be effective on the date received, but is NOT retroactive to release of information made in good faith. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS related information and psychiatric/mental health information. A photocopy of this form will be considered as valid as the original. My refusal to sign this authorization will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment.

This authorization will expire (date/event) _____ or once this request has been fulfilled. The undersigned hereby releases the above-mentioned institution from any liability which may arise from release and/or examination of the information indicated above.

Signature of patient or legal representative: _____

Relationship to patient: _____ Date:_____