willamette falls pediatric group

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

OREGON CITY
1510 Division Street, Suite 280, Oregon City, OR 97045
T 503.905.3400 • F 503.905.3399

CANBY
200 Hazel Dell Way, Suite 202, Canby, OR 97013
T 503.266.8500 • F 503.266.8585

All sections of this form MUST be completed or the authorization will not be accepted.

I authorize: _____

_____

To use and disclose a copy of the specific health information described below regarding:

_____ _____
(name of individual) (date of birth)

Consisting of: ___ Physician Reports ___ X-rays ___ Labs ___ Other (specify) _____

To: **Willamette Falls Pediatric Group, 1510 Division St. Suite 280, Oregon City, OR 97045**

For the purpose of: ___ Continued Care ___ 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 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 circumstances 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 purpose 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; WFPG, 1510 Division St. Suite 280, Oregon City, OR 97045,** and state that you are revoking this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to Redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure 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.

Signature _____ Date _____

Description of personal representative's authority: _____