Authorization for Use and Disclosure of Protected Health Information
Valley Women's Health

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Patient Name: _____ Date of Birth: _____ /____/_____

Address: _____

Social Security #: _____ Telephone: (_____) _____

The patient named above is requesting the following records *Released from / Sent to* *(circle one):*

Business Name/ Person: _____

Address: _____

_____

Telephone: (____) _____ Fax: (____) _____

Dates to be released

From date: _____

To date: _____

PURPOSE OF REQUEST: ☐ Treatment or consultation ☐ At the request of the patient ☐ Continuity of Care

TYPE OF INFORMATION TO BE RELEASED:

_____ Emergency room report _____ Laboratory test reports _____Ultrasound reports

_____Operative report _____ History & Physical exam _____ Pap Tests

_____ Diagnostic test results _____ Consultation reports _____ Itemized bill

Other: _____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Valley Women's Health. Unless revoked, this authorization will expire in 180 days or on the following date or event: _____.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release. ___**NO** __ **YES**____**Initials**

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ____ **NO** ____ **YES** _____ **Initials**

Release via Unencrypted Email ONLY

I understand that I am specifically requesting my medical record be sent electronically via email, I understand there is a risk of it being read or accessed by a third party while in transit and still wish to receive my records in this manner, I agree to its release. ___**NO** __ **YES**____ **Initials**

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Valley Women's Health may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize Valley Women's Health to use and disclose the protected health information specified above.

Signature: _____ Date: _____

Fax records to: (503) 434-6148 **OR Mail to:**

Valley Women's Health
2700 SE Stratus Avenue, Suite 301
McMinnville, OR, 97128