Coquille Valley Hospital

940 East 5th Street, Coquille, Oregon 97423
Main Phone: 541-396-3101

Medical Records Phone (541) 396-1058 Medical Records Fax (541) 396-7374

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PROVIDE PHOTO IDENTIFICATION. IF YOU ARE MAILING OR FAXING THE FORM AND WOULD LIKE YOUR RECORDS MAILED, PLEASE SEND A COPY OF YOUR PHOTO IDENTIFICATION.

Patient Information	**Name:** _____ **Date of Birth:** _____ **Address:** _____ **Phone Number:** _____
Clinic/Hospital/Healthcare Provider (**Who** has the information you want released?)	**Name of Facility/Person:** _____ **Address:** _____ **Phone Number:** _____ **Fax Number:** _____
Receiving Party (**Where** do you want the information sent? **Who** may have the information?)	**Name of Facility/Person:** _____ **Address:** _____ **Phone Number:** _____ **Fax Number:** _____
Information to be Released (**What** do you want released? Check the appropriate box(es))	☐Discharge Summary ☐Clinic Notes ☐Emergency Room Notes ☐Operative/Procedure Notes ☐Billing/Payment Information ☐Radiology Images ☐Radiology Reports ☐History and Physical ☐Labs ☐Verbal Information Only ☐ Psychiatric/Mental Health ☐Last 2 years ☐Other_____
	INITIAL TO CONSENT RELEASE OF THE FOLLOWING **____Mental Health ____HIV/AIDS ____Genetic Testing** **____Drug/Alcohol Treatment/Referral/Diagnosis Information ____ Reproductive Health**
Release Instructions (**How** do you want the information?)	**Release Method: (Check One)** ☐ Fax ☐ Mail ☐ Pick Up ☐ Kept on File **FAX: 541-396-7374** **ADDRESS: 940 East 5th Street Coquille, Oregon 97423**
Purpose of Release (**Why** is it needed?)	☐ Treatment/Continuity of Care ☐ Legal ☐ Transfer of Care ☐ Other

I authorize the use and disclosure of my protected health information as described above. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy laws, the information described below may be re-disclosed and is no longer protected by those regulations. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS, mental health, genetic testing, and drug/alcohol diagnosis, treatment, or referral information. If the information to be disclosed contains any of the sensitive records listed above, additional laws relating to the use and disclosure of this information may apply. I understand and agree that with my initials, I am allowing this information to be disclosed. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or determine my eligibility for benefits unless allowed by law. Coquille Valley Hospital is allowed by law 30 days to respond to a request for medical records. I understand that I may inspect, or request copies of any information disclosed by this authorization.

This authorization will expire in 365 days unless specified here. _____

If this authorization is for a research study, the authorization will expire at the end of the research study. I understand that I may revoke this authorization at any time by notifying Coquille Valley Hospital Health Information Management in writing at the above address, except to the extent that action has been taken in reliance on this authorization.

Patient Signature (15 years and up)	Date
Representative Signature (Please include supporting documentation)	Relation to Patient

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For Internal Use Only

Date Records Sent: _____

ID Verified By:_____

Completed By:_____

Method of Identification:

- ☐ **Driver's License**
- ☐ **Signature Comparison**
- ☐ **Other_____**