UMPQUA HEALTH
NEWTON CREEK

Instructions for completion of "Authorization to Use and/or Disclose Protected Health Information"

If you are requesting information to be released to someone other than yourself, complete all sections of this form as directed.

1. Print the name and address of the health care provider, clinic or hospital that is to release information.

2. Print the name and address of the person or entity that is to receive your information, under "To use/disclose medical information to."

3. Print the full name of the patient, including middle initial in "Patient Name" box.

4. Identify the date(s) of service of the health care information you would like released.

5. Identify the reason for the requested release in the "Purpose" box.

6. Print the patient's social security number (optional).

7. Print the patient's Date of Birth.

8. Print other names used by the patient.

9. Include the patient's or personal representative's phone number.

10. Initial in the space provided for each type of medical record/information you wish to disclose to the recipient. Initial next to any specially protected records that you would like disclosed (Specially protected information is identified with an asterisk).

11. Fill in an expiration date or event. An example of an event is, "while I am receiving services at this facility." If left blank, authorization will expire one year from the date of signing the form.

12. Sign your name if you are the patient or the patient's legal representative on the "Signature" line.

13. Indicate the date you are signing the form.

14. Print the patient's name or name of legal representative if applicable.

15. Write your relationship to the patient if you are not the patient.

16. Retain a copy of the authorization for yourself.

If you are the legal representative for the patient please attach a copy of the Power of Attorney, Death Certificate or Probate form.

UMPQUA HEALTH
NEWTON CREEK

Authorization to Use and/or Disclose Protected Health Information

I authorize the following health care provider(s) to use, share and disclose medical information of the patient named below, as follows:

Health Care Provider who is disclosing Information:

UMPQUA HEALTH NEWTON CREEK, LLC.

Name of provider, clinic, or hospital

3031 NE STEPHENS ST.

Street Address

ROSEBURG, OR 97470

City, State, Zip

541-229-7038 Phone **541-464-4641** Fax

Person or Organization who is receiving information:

Name (if an individual, include affiliated institution, if any)

Street Address

City, State, Zip

Phone Fax

Patient Name:	Date(s) of Service, if applicable:	Patient ID Number:
Date of Birth:	Other Names Used:	Patient's or Person Representative's Phone:

Describe each purpose of disclosure, or indicate that the disclosure is at the request of the individual:

_____ At the request of the individual (initial in the space provided); **OR**

_____

By **initialing** the spaces below, I authorize the use and/or disclosure of the following:

_____ Entire Medical record (except the Specially Protected Information identified by the asterisk below)

_____ Partial record, including (check all that apply):

____ Clinic Records
____ Transcribed Hospital Reports
____ Progress Notes
____ Emergency and Urgent Care Records
____ Photographs and Videotapes
____ Demographic Sheet/Face Sheet
____ Dental Records
____ Laboratory Reports
____ Pathology Reports
____ Diagnostic Imaging Reports
____ Billing Statements
____ Other: _____

*Specially Protected Information: Except as specifically permitted by law, the following types of information will not be disclosed unless I authorize the disclosure by **placing my initials** in the space(s) next to type of information to be disclosed:

_____ *HIV – Positive test results and HIV diagnosis
_____ *Mental Health information and/or records
_____ *Genetic testing information and/or records (Oregon ONLY)
_____ *Other sexually transmitted diseases (Washington ONLY)
_____ *Drug/alcohol diagnosis, treatment, or referral information

ROI Taken by:_____

Delivery Method:_____

UMPQUA HEALTH
NEWTON CREEK

Authorization to Use and/or Disclose Protected Health Information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal and state law. However, I also understand that federal or state law may restrict re-disclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization.
Revocation shall be sent to _____ (contact) at _____ (address), identifying you by name and by birth date or patient identification number, and stating that you are revoking this authorization.

If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire one year from the date of signing on _____ (date), or as otherwise identified here: _____

_____	_____
Signature of Patient *or Patient's Legal Representative*	***Date***
_____	_____
Print Name of Legal Representative (if applicable)	***Relationship to Patient***

** Patients of the following ages must sign this form to release their PHI to any person or facility, except when release to a parent or guardian is permitted by law or regulation:

- 14 years of age and above: All medical conditions (Washington); mental health and chemical dependency (Oregon)
- 15 years of age and above: All other medical conditions (Oregon)

*** If you are not the patient's parent, please attach documentation of your authority***

☐ Legal Representative's authority to act as Representative verified
☐ Patient's or Legal Representative's Personal Identification Verified

ROI processed by: _____