AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Bay Area Hospital – 1775 Thompson Road – Coos Bay, OR 97420 – (541) 269-8157 Fax: (541) 269-5787
BAH Psychiatric Clinic – 2085 Thompson Road – Coos Bay, OR 97420 – (541) 269-5333 Fax: (541) 269-5609
BAH Radiology Services – 1775 Thompson Road – Coos Bay OR 97420 – (541) 269-8090 Fax: (541) 269-8571

1. **I authorize the use or disclosure (release) of my protected health information as described below**. I understand that if the person(s) or entity(ies) that receives the information is not a healthcare provider or health plan covered by federal privacy laws, the information described below may be redisclosed and is no longer protected by those regulations (45 CFR Part 164).

2. **Bay Area Hospital is authorized to**: (Select One) ☐ **DISCLOSE TO** ***or*** ☐ **OBTAIN FROM**

   Person(s) or Facility Name: ______________________________

   Street Address: ______________________________

   City ______________________ State ____________ Zip ____________

   Phone ______________________ Fax / Email ______________________

   The following information from the medical records of:

   Patient Name: ________________ Date of Birth: ________________ MRN ____________

   Specific Date or Time Period: ______________________________

3. Please specify or describe the information that you are requesting or choose from below:

☐	History & Physical	☐	Laboratory
☐	Discharge Summary	☐	Radiology/Imaging Report
☐	Emergency Department	☐	X-ray Image
☐	Pertinent information	☐	Entire Chart

Other: ______________________________

Initials	**SENSITIVE INFORMATION:** Drug and/or Alcohol Treatment Records[1]
	Mental Health Treatment Records
	HIV / AIDS
	Genetic Testing Information

4. The purpose for my request is: (Please list and describe all purposes.) ______________________________

   ____

5. 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.

6. I understand I may inspect or request copies of any information disclosed by this authorization. I ask that this authorization expire on (date) ______________ or on (an event) ______________ . If no date or event is specified, this authorization will be in effect for a period of six (6) months from the date signed below. Upon conclusion of that time period (unless earlier revoked by me in writing), this authorization is automatically revoked. 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 Bay Area Hospital in writing except to the extent that action has been taken in reliance on this authorization.

7. I understand that Bay Area Hospital is permitted by federal and state law to impose photocopying fees of the requested information including the cost of supplies, labor, and postage (if mailed). I will be informed of the estimated photocopying fees in advance of receiving copies of my medical record. Receiving copies of my records will not be contingent upon my ability to pay these fees. Bay Area Hospital is allowed by law up to 30 days to respond to a request for medical records or up to 60 days if records are not stored on hospital premises.

SIGNATURES

______________________________ ______________ ________
Signature of patient or patient's authorized representative — Date — Time

______________________________ ______________________________
Printed name of patient or patient's authorized representative — Relationship to patient and authority to act for the patient

[1] This specific and sensitive information is protected separately by Federal confidentiality rules (42 CFR Part 2). The Federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written permission of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any Alcohol or Drug Abuse patient (42 CFR 2.32).

OFFICE USE ONLY

Date authorization received: ______________________________________

Identifiers: ☐ Medical Record # __________________ ☐ SSN _________________ ☐ DOB _________________

Date information copied: ____

Information released by (Name): ____

Information released (cannot be more than allowed by this authorization): ___________________________________
____

Number of page(s) copied: ______________________ Charge(s)(if any): __________________________________

Mode of release: ☐ In person ☐ via US Mail ☐ via Fax# ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

☐ FedEx ☐ Other alternative method ____

Personal identification verified (**Do Not Record**): ☐ Driver's license ☐ Military ID ☐ Badge ☐ Other photo ID