Authorization for Use or Disclosure of Health Information

Review all sections, date and sign.

I. I, _____, authorize the disclosure of my personal health information as described in Sections III and IV below. I understand this authorization is voluntary.

II.

This information is to be disclosed by:	**And is to be provided to:**
FACILITY NAME	FACILITY NAME
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE
PHONE	PHONE
FAX	FAX

III. Personal Health Information to be Disclosed pursuant to this authorization:

- ☐ Entire medical record
- ☐ Information in my medical record related to (*specify medical condition*):_____
- ☐ Only the period of events from (*specify*)_____
- ☐ **Psychotherapy chart notes ONLY** (*by checking this box, I waive any psychotherapist-patient privilege*)

IV. Sensitive Information.

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 if I place my initials in the applicable space next to the type of information. **If you would like any of the following sensitive information disclosed, place your initials on the line(s) below:**

- ☐ Alcohol / Drug abuse treatment or referral
- ☐ HIV- or AIDS-related treatment
- ☐ Sexually Transmitted Diseases
- ☐ Mental health (other than psychotherapy chart notes)

V. Purpose of the Disclosure.

The disclosure is being made for the following reasons:

- ☐ For an accommodation request under the Americans with Disabilities Act (ADA)
- ☐ For a Family Medical Leave Act (FMLA) or Oregon Family Leave Act (OFLA) request
- ☐ For a Fitness for Duty evaluation
- ☐ Other (*specify*): _____

VI. Genetic Information Non-discrimination Act (GINA).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, **we are asking that you not provide any genetic information when responding to this request for medical information.** 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

VII. Right to Revoke.

I may revoke this authorization at any time by notifying _____ in writing. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization except to the extent that action has been taken in reliance on this authorization.

Redisclosure: I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

VIII. Signature.

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 circumstance when refusal to sign means you will not receive service 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. **For employment purposes under the Americans with Disabilities Act, refusal to sign this authorization will result in the employer making employment decisions based on available information.**

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the plan named above. I understand that, by signing this form, I am confirming my authorization that the provider named above may use and/or disclose to the persons and/or organizations named in this form the personal health information described in this form. Unless revoked, this authorization expires _____ (*insert either applicable date or event*).

Signature: _____ *Date:* _____

IX. Personal Representatives Section.

Personal Representative's Name: _____

Personal Representative's Signature: _____

Personal Representative's authority to act:

- ☐ Legal Guardian for minor (under age of 18) or for adult (as established by a court order)
- ☐ Holds Power of Attorney
- ☐ Other (*specify*): _____

BHR BUREAU OF HUMAN RESOURCES

Instructions for Completing this Authorization Form

1. Section I, **print** name of individual whose information is to be released.
2. Section II, **print** the name and address of the facility releasing the information. Also, provide the name of the facility and address that will receive the information.
3. Section III, describe what information is to be disclosed and check appropriate box:
    a. **Entire Record** – the complete record except for sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV- or AIDS-related treatment, and mental health information other than psychotherapy notes)
    b. **Only information related to** a specific diagnosis, injury, operations, special therapies, etc.
    c. **Only the period of events from** – specify date range, e.g. 01/15/2000 to 02/15/2000
    d. **Psychotherapy notes ONLY** – if this box is checked with other boxes, another authorization will be required to authorize the use or disclosure of psychotherapy notes only.
4. Section IV, in order to release sensitive information related to alcohol/drug abuse treatment/referral, HIV- or AIDS-related treatment, sexually transmitted diseases, or mental health information (other than psychotherapy notes), you **must** check the appropriate box.
5. Section V, state the why medical information is needed, e.g. disability claim or continuing medical care
6. Section VI, Fill in Provider or Plan to contact for revocation.
7. Section VIII, sign and date. If a different expiration date is desired, specify a new date.
8. Section IX, Authorized Representative, e.g., legal guardian, power of attorney, etc.
9. Give a copy of the completed form to the individual or personal representative.