St. Charles
HEALTH SYSTEM

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

Address: _____ City: _____ State: ___ Zip: _____

Email: _____ Phone: _____

2 Purpose for requesting information: ❑ Legal ❑ Insurance ❑ Personal ❑ Continuation of Care ❑ Other

Please complete the following section, using a separate form for each sender or recipient of the medical records. This form can be used for records of St. Charles Health System or records of other health care providers.

3 Check one: ❑ FROM ❑ TO

St. Charles Health System:

❑ St. Charles Bend hospital

❑ St. Charles Redmond hospital

❑ St. Charles Madras hospital

❑ St. Charles Prineville hospital

❑ St. Charles Sage View

❑ St. Charles Medical Group: write in clinic name(s).

_____

_____

_____

_____

4 Check one: ❑ FROM ❑ TO

❑ Same name and address as listed above ❑ Other

Sender / Recipient Name:

_____

Address: _____

City: _____ State: ____ Zip _____

Phone: _____ Fax: _____

Email: _____

5 Date Range of Services: _____ to _____

I authorize the following information to be released from the medical record(s)

If not specified - the record with the most recent service from each area requested below.

6 ***Note: Standard copy fees will apply subject to federal and state regulations.***

❑ Hospital Summary *(Includes: Discharge Summary, History & Physical, Operative Report(s), Anesthesia Record, Consultations, Diagnostic Test Results, Radiology, Lab, etc.)*

❑ Clinical Summary *(Includes: Clinical/Office Notes, Consultations, Diagnostic Test Results, Radiology, Lab, EKG, etc.)*

❑ Emergency Room Record

❑ Lab Report(s)

❑ Radiology Report(s)

❑ Radiology Film / Imaging Studies / Tracings

❑ Itemized Billing Records

❑ Complete Legal Medical Record

❑ Only last two years of legal medical records

❑ Other: _____

_____

_____

_____

INSTRUCTIONS

1. Enter the name, date of birth, address, email (if applicable) and phone number of the patient whose records you would like to send or receive.
2. Select the purpose of your request: legal, insurance, personal, continuation of care, or other (please specify).
3. Check with the 'From' or 'To' box, then identify and provide the contact information for the sender or recipient of the medical records, as applicable.
4. Check with the 'From' or 'To' box, then identify and provide the contact information for the sender or recipient of the medical records, as applicable.
5. Enter the date range of services for which you are requesting records.
6. This is the basic information that health care providers commonly request. Check the box/boxes stating what types of records you are requesting. If requesting something other than what is stated, check "other" and write the information you would like.

* 3 R O I *

I understand that the medical records may contain sensitive or specially-protected information. Please initial those types of sensitive information that you would like to have released.

In some situations, state and federal law protect the following information. If this information applies to you, please indicate whether you would like this information to be released:

7

Alcohol, Drug or Substance Abuse Records	_____ Initial Required
HIV Testing Records	_____ Initial Required
Mental Health Records	_____ Initial Required
Genetic Records	_____ Initial Required

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal and state regulations.
- I have the right to revoke (take back or change my mind about) this authorization at any time. To do this, a request must be made in writing and provided or mailed to the St. Charles Health System Manager of Health Information Management.
- If I ask to revoke an authorization that was signed by me on a previous date, the request to revoke will not apply to records that were already copied and released as a result of the original and authorized request.
- Unless I revoke this authorization, it will expire on the following date or event: _____ . If an expiration date is not specified, this authorization will expire one year from the date it is signed.
- No determination about treatment, payment, enrollment, or eligibility for benefits will be based on whether or not I sign this authorization form.
- I understand that federal confidentiality rules will not protect the medical information that I have authorized to be released, if it is released again by the organization or person that receives it.

8 Records Format (paper is default if not marked):

❑ Paper ❑ CD ❑ No records requested

Delivery Options (Please note: Standard copy fees may apply subject to federal and state regulations)

❑ U.S. Mail ❑ Fax ❑ Pick up

9

_____ _____

Patient or Authorized Representative Signature | Date

_____ _____

Print Name | Relationship to Patient (if applicable)

(For Office Use Only)

10

Name of Caregiver Accepting Authorization:	Department

Note: This form is a permanent part of the medical record.

St. Charles Health Information Management | 2500 NE Neff Road, Bend, OR 97701 | Phone: 541-382-4321 ext. 7784

INSTRUCTIONS CONT.

7. In some cases, a health care provider may be prohibited from releasing those types of records that are not initialed.
8. Check the box indicating the format in which you would like to have the records sent or received. Note: Faxes are only sent to other healthcare provider's offices.
9. The person authorizing the release must sign, date, print his or her name, and indicate his or her relationship to the patient. No drug and alcohol treatment records of a minor who is 14 years old or older, nor medical records of any type of a minor who is 15 years old or older, may be released without the minor's written authorization if the minor self-consented to the treatment associated with the records. St. Charles reserves the right to reject this authorization form if the legal authority of the representative cannot be validated.
10. St. Charles staff accepting the release must sign and document department.