MR#_____

Tillamook County
Land of Cheese, Trees and Ocean Breeze

**TILLAMOOK COUNTY HEALTH SERVICES**
**801 Pacific Ave, P.O. BOX 489**
**Tillamook, OR 97141**
**Phone: (503) 842-3900 or 1-800-528-2938 Fax: (503) 842-3903**
**TTY: Oregon Relay Service 1-800-735-2900**

# AUTHORIZATION
# TO USE/DISCLOSE HEALTH INFORMATION

I authorize:_____
(*Name of physician/physician group*)

to use and disclose a copy of the specific health and medical information described below regarding:

_____ _____
*(Name of patient)* *(Date of Birth)*

consisting of: _____

_____

*(Describe information to be used/disclosed)*

to: _____
(*Name and address of recipient or class of recipients*)

for the purpose of:_____
*(Describe <u>each</u> purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.*)

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 **<u>initials</u>** in the applicable space next to the type of information.

____ HIV/AIDS information _____ Mental health information

_____ Genetic testing information _____ Drug/alcohol diagnosis, treatment, or referral information

**I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. <u>However</u>, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information**

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to _____(contact person) at _____(address of person/entity disclosing information) and state that you are revoking this authorization.

Unless revoked, this authorization will expire on the earlier of _____ (date),180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above described purpose.

I have read this authorization and I understand it.

By: _____ Date _____
(Patient or personal representative)

Description of personal representative's authority: _____