PLEASE PROVIDE PHOTO IDENTIFICATION. IF YOU ARE MAILING OR FAXING THIS FORM, AND WOULD LIKE YOUR RECORDS MAILED TO YOU, PLEASE SEND A COPY OF YOUR PHOTO IDENTIFICATION.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Bay Area Cancer Center – 1775 Thompson Road – Coos Bay, OR 97420 – 541-269-4160 FAX: 541-269-4179
Bay Area Hospital (BAH) – 1775 Thompson Road – Coos Bay, OR 97420 – 541-269-8157 FAX: 541-269-5787
BAH Radiology Services – 1775 Thompson Road – Coos Bay, OR 97420 – 541-269-8090 FAX: 541-266-7823
Prefontaine Cardiovascular Clinic – 1775 Thompson Road – Coos Bay, OR 97420 – 541-266-4650 FAX: 541-266-4659

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
   ☐ Discharge Summary
   ☐ Emergency Department
   ☐ Pertinent information
   ☐ Laboratory
   ☐ Radiology/Imaging Report
   ☐ X-ray Image
   ☐ 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 action has been taken in reliance on this authorization.
7. I understand 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