CITY OF PORTLAND, BUREAU OF HUMAN RESOURCES
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. The information is to be disclosed by: **And is to be provided to:**

NAME OF FACILITY	NAME OF FACILITY
ADDRESS	ADDRESS/ PHONE NUMBER
CITY/STATE	CITY/STATE

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

☐ Entire Medical Record
☐ Information, including entire medical record, related to (specify medical condition)_____
☐ Only the period of events from (specify)_____
☐ **Psychotherapy Chart Notes ONLY (by checking this box, I am waiving 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/Referral
____ HIV/AIDS – related Treatment
____ Sexually Transmitted Diseases
____ Mental Health (Other than Psychotherapy Notes)

V. Purpose of the Disclosure: The disclosure is being made for the following reasons:

VI. Genetic Information Nondiscrimination 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

If a personal representative wants to sign this authorization on behalf of an individual, complete the following:

Signature of Personal Representative: _____

Personal Representative's Name: _____

Description of Representative's authority to act:

INSTRUCTIONS FOR COMPLETING THIS 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 person, 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 the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS related treatment, and mental health other than psychotherapy notes)
   b. **Only information related to** – specific diagnosis, injury, operations, special therapies, etc.
   c. **Only the period of events from** – specify date range, e.g., January 1, 2001 to February 1, 2002.
   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 ALCHOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU <u>MUST</u> CHECK THE APPROPRIATE BOX.**
5. State the reason why the information is needed, e.g., disability claim, continuing medical care, legal, etc.
6. 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.