OSA
Oregon Sleep Associates

2228 NW Pettygrove St, Suite 150, Portland OR 97210
Phone 503-288-5201 ~ Fax 503-288-0151

Authorization to Use / Disclose Protected Health Information

I authorize _____*(name of physician/physician group)* to use and disclose a copy of the specific health information described below regarding _____*(patient)* consisting of: *DOB:*_____/_____/_____

☐Sleep Studies ☐History and Physical ☐Chart Notes ☐Entire Medical Record

to: _____ _____ *(name and address of recipients)* for the purpose of:

☐Coordination of Care ☐At the request of the individual ☐Other: _____

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.

____ HIV/AIDS information
____ Mental health information
____ Genetic testing information
____ Drug/alcohol diagnosis, treatment, or referral information
____ Psychotherapy notes

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. 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.

You do not need to sign this authorization. Refusal to sign this 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 health care services 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.

You have the right to 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. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization please send a written statement to Oregon Sleep Associates Practice Manager at 2228 NW Pettygrove, Suite 150 Portland, OR 97210 and state that you are revoking this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert date or applicable event) _____.

I have read this authorization and I understand it.

_____ _____

Signature of Patient of Patient's Legal Representative *Date*

_____ _____

Print Patient's name or name of Legal Representative (if applicable) *Relationship to Patient*

FAX this form with requested patient records to 503-288-0151