Portland Office:
9427 SW Barnes Road, Suite 498
Portland, Oregon 97225
503-297-6234 Fax: 503-297-3121

Newberg Office:
1003 Providence Drive, Suite 325
Newberg, Oregon 97132
503-554-1187 Fax: 503-554-8486

Orenco Office:
5555 NE Elam Young Parkway
Hillsboro, Oregon 97124
Fax: 503-216-1655

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

This form must be completely and legibly filled out or Columbia Cardiology Associates, LTD (CCA) may not be able to release the information.

1. Line 1. Complete the individual/patient's name and date of birth for the person whose records are being disclosed; identify the name of the facility that you are allowing to disclose your information; and the name and address of the party authorized to receive the healthcare information.
2. Line 2. Identify the specific healthcare records you want sent or released. This can be for date ranges (the last two years), or specific episodes of care or procedures. Remember there are costs to reproduce records, so requesting specific information rather than the entire record will save money.
3. Line 3. State the specific purpose of the release. CCA can only release information for a specific purpose, such as legal, life insurance eligibility, or research eligibility evaluation. CCA cannot accept authorizations for multiple purposes; a separate form is needed for each purpose.
4. Line 4. If the records contain any specially protected information, CCA can only release them if the patient initials each type of information.
5. Lines 5 & 6. CCA is required by Oregon State Law to include this information on the authorization form.
6. Line 7. This line explains your right to revoke this authorization. The name and address will be completed by CCA and tells you where to send a request to revoke an authorization.
7. Line 8. An authorization must have an expiration date or event, whichever is best suited for the purpose of the authorization.

Please have the patient sign the form. If a personal representative completes the authorization, CCA must have proof of the authority of the person to act in that capacity.

Distribution: Medical Record/Chart (Original)

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. **Patient** (Please print)____**Date of Birth** (_ _/_ _/_ _)
   I authorize ___________________________________ to disclose a copy of my Protected Health Information to:

   Recipient: ____

   Address: ____

   City: ________________________________State: ________ ZIP: ____________

   Telephone: ______________________________ Fax: __________________________

2. **The specific health care information to be used/disclosed consists of:**
   ☐ The past 2 years of pertinent information, ☐ For dates of service from (_ _/_ _/_ _) to (_ _/_ _/_ _)
   ☐ Office Notes ☐Operative Report ☐EKG ☐ Thallium/Treadmill ☐ Lab ☐ Holter/Event Monitor
   ☐ ECHO/Stress Echo ☐ Other (specify): ____

3. **The purpose of the use/disclosure is for:** ☐ Insurance ☐ Disability ☐ Legal__________________

   ☐ Other____

4. 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.
   ______Genetic testing information ______ Mental health information ______HIV/AIDS information

   ______ Drug/alcohol diagnosis, treatment, or referral information

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

6. 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. Refusal to sign this authorization means you will not receive health care services if the health care services are solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.

7. You may revoke this authorization in writing at any time. If you revoke this 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 CCA 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 AND state that you are revoking this authorization to:

   Columbia Cardiology Associates, Attn: HIPPA Compliance Officer
   9427 SW Barnes Road, Suite 498, Portland, Oregon 97225

8. I have read this authorization and I understand it. Unless revoked, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

9. **Signature:** ____ ____________________
   Patient or Personal Representative **Date**

   Personal Representative's Name/Authority (please print): ____

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