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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)

Revised Date: Sept. 8, 2009

Release to CCA from Other

