Samaritan
Health Services

Authorization to Disclose Health Information

INSTRUCTIONS for COMPLETING THE AUTHORIZATION

For this authorization to be valid all sections must be complete, signed, and dated by me or on my behalf by a personal representative.

Treatment and/or reimbursement for services may not be withheld or conditioned on obtaining this authorization. I may refuse to sign this authorization.

I understand that I have the right to a copy of this authorization form.

SIGNATURE: The patient's signature is required. If the patient is incapable of signing the authorization, a personal representative such as the parent or legal guardian of a minor, or someone designated in a health care power of attorney or advance directive of the patient may sign on the patient's behalf. Legal documentation showing the authority to act for the patient may be required, prior to the request for medical records being processed. Examples of acceptable documentation include: Health Care Power of Attorney, Death Certificate, or Court Order.

OTHER IMPORTANT INFORMATION:

CANCELLATION/ REVOCATION: I may revoke (cancel) this authorization in writing at any time. The written request does not apply to information that has already been released in accordance to this authorization. To cancel this authorization it must be in writing and signed by me or on my behalf by a personal representative. I must send a copy of this authorization and my written statement revoking this authorization to Samaritan Health Services, Health Information Management (HIM) Department, PO Box 2728, Corvallis, OR 97333.

DISCLOSURE/ REDISCLOSURE: If disclosure of this health information is to someone who is not legally required to keep it confidential, it may be redisclosed and may be no longer protected.

METHOD OF DELIVERY:
Fax: Samaritan Health will only fax health information to another health facility if I have marked 'continuing care' as the purpose of this request. You will need to provide the fax number on this authorization.
MyChart: Records released to MyChart account are only available to access for 90 days.

FEES: Fees may apply to certain requests. There is no charge for information sent to another health care provider or organization for continuing patient care. For other types of requests, I will be advised if there is a fee and I must initial at the bottom of page one of the authorization form. Reasonable cost based fees include the cost of producing copies of the requested record including supplies, labor, and postage.

MINORS: In the state of Oregon, minors may be able to request certain levels of confidentiality or consent to various health care matters depending on their age without parental consent. When a minor presents for treatment as described above, it is Samaritan Health Services policy to require the minor to authorize disclosure of those medical records. (Reference; ORS 109.675, 109.610, 109.640)

Contact Information

PLEASE RETURN YOUR AUTHORIZATION FORM(S) TO ONE OF THE ADDRESSES LISTED BELOW
If you have any questions or need assistance in completing this form, please call the SHS HIM department.

SHS HIM Corvallis	SHS HIM Albany	SHS HIM Lebanon	SHS HIM Newport	SHS HIM Lincoln City
3600 NW Samaritan Drive	1046 Sixth Ave. SW	525 N. Santiam Hwy.	930 SW Abbey St.	3043 NE 28th St.
Corvallis, OR 97330	Albany, OR 97321	Lebanon, OR 97355	Newport, OR 97635	Lincoln City, OR 97367
Phone: (541)768-5069	Phone: (541)812-4140	Phone: (541)451-7143	Phone: (541)574-1813	Phone: (541)996-7162
Fax: (541)768-6798	Fax: (541)812-4139	Fax: (541)451-7071	Fax: (541)574-1836	Fax: (541)996-7310

Samaritan Health Services

Authorization to Disclose Health Information

Patient Name: _____

Date of Birth: _____ **Ph. #:** _____ MRN (if known): _____

I authorize Samaritan Health Services (check facility): ❑ All or specify below which facility

❑ Corvallis -GSRMC ❑ Albany -SAGH ❑ Lebanon -SLCH ❑ Lincoln City -SNLH ❑ Newport -SPCH ❑ Clinics

❑ Other, specify: _____

To do the following: ❑ Send information to: ❑ Receive information from:

_____ _____ _____
Facility/Person (first and last name) Phone Number E-mail Address

_____ _____
Street Address, City, State, Zip Code Fax Number

Forward incoming information to: _____
(First and Last Name, Department, and City/Town)

For dates of services from: _____ to: _____

For information related to the following diagnosis or injury: _____

_____

By checking the boxes below, I specifically authorize the release of the following medical records, if such records exist:

❑ Pertinent Records (Provider reports, problem list, medication, immunization & allergy lists, lab, x-ray, and EKG)

Reports ❑ History & Physical ❑ Consultations ❑ Discharge Summary ❑ Operative ❑ Procedure Reports

Diagnostic Reports ❑ X-ray Images ❑ X-ray Reports ❑ EKG ❑ MRI ❑ Ultrasound ❑ Laboratory/Pathology

❑ Emergency/Urgent Care Records ❑ Clinic/Office Visit Provider Notes

❑ Therapy (PT/OT/ST) Records ❑ Immunization Record

❑ Billing Statements ❑ Other (specify): _____

_____

Important Conditions: By checking the box(es) below and placing your initials here _____ (initial), you agree to the release of the following:

❑ HIV Test Results ❑ Genetic Testing ❑ Mental Health Specific Visits ❑ Drug/ Alcohol Specific Visits

Purpose of Release: ❑ Continuing Care ❑ Personal ❑ School ❑ Legal ❑ Insurance ❑ Disability

❑ Other, specify: _____

My preferred format is:	My preferred method of delivery is:
❑ Electronic -No fee	Requested records are released to MyChart
❑ Paper	❑ In Person ❑ Mail ❑ Fax (for continued care only)
❑ CD	❑ In Person ❑ Mail

- I understand there may be a fee assessed for providing this information _____ (initials)
- **I understand the instructions and information on page 1 and 2 of this authorization**. Unless canceled (revoked), this authorization expires on _____ (date or event) or 365 days from the date I signed this form.

_____ _____ _____
Signature of Patient or Patient Representative Relationship to Patient **Date signed**

_____
Print Name of Signature

This box is to be completed by SHS ONLY

Date Received: _____ ❑ **ID Verified**

Epic Release ID: _____

Staff reviewed for completeness - Initials: _____