PENDLETON
Community Care, Inc.

Patient Authorization for Use and/or Disclosure
Of Protected Health Information at Request of Health Center

Patient Name (list full name and print): _____
Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

I request and authorize: list names of person(s) or organization(s) authorized to release health care records containing PHI to:
_____ Phone: _____

To release health records containing PHI to: list names of person(s) or organization(s) to whom health records containing PHI are to be sent:
Name (or title) of recipient: _____
Address: _____
City, State, Zip: _____
(List any additional organizations in an attachment. Attachment must be signed to be valid. Unless other instructions are provided, we will mail the requested information to the party listed above.) Alternative instructions: please send the requested information as follows:
_____

You may use or disclose the following health care information (check all that apply):
☐ All health care information in my medical record. List reason: _____
☐ Health care information in my medical record relating to the following treatment or condition:
_____
☐ Health care information in my medical record for the date(s):
_____
☐ Other (e.g. X-rays, bills), specify date(s):
_____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (initial all that apply):
_____HIV (AIDS virus)
_____Sexually transmitted diseases
_____Psychiatric disorders/mental health (other than psychotherapy notes)
_____Drug and/or alcohol use (further re-disclosure limited or prohibited by 42 CFR Part 2)
☑ Integrated behavioral health notes as part of the medical record
_____Psychotherapy notes (if applicable, no other information can be released pursuant to this authorization)

Format patient would like to receive records: ☐Paper ☐Disc ☐Fax

Reason(s) for this authorization (check all that apply): These purposes are provided to me so I can make an informed decision whether to allow the use and/or disclosure requested by PCC/NFC/HHC:
☐ For PCC/NFC/HHC use for: _____

☐ Other (specify): _____

☐Check only if PCC/NFC/HHC has requested the authorization for marketing purposes

☐ Check only if PCC/NFC/HHC will be paid or get something of value for providing health information for marketing purpose

I authorize the release of the PHI identified above:

☐ Created on or before the date of this request only

☐ Created on or before the date of this request and created after the date of this request for health care services I receive through the period up to and including the expiration date listed below.

This authorization ends: (This document does not permit disclosure of health information for a period of more than one year after the date it is signed.)

☐ _____ Days from the date signed ☐ On (date): _____/_____/_____

☐ When the following event occurs: _____

(No longer than one year from date signed)

(If no date or event is stated, expiration will be one year from the date signed.)
We cannot use or disclose the requested information after expiration of this authorization without the execution and delivery to us of a new authorization.

- I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment, or enrollment) and that I may refuse to sign this authorization. However, I do have to sign an authorization form:
  - To take part in a research study: or
  - To receive health care for the express purpose of creating health care information for a third party (i.e. life insurance physical).
- I understand that I have the right to inspect or copy the PHI to be used or disclosed by Health Center pursuant to this authorization. I also understand that I will be provided a copy of this authorization.
- I understand that this authorization may be revoked in writing and delivered to the Heath Center Privacy Officer at any time, although revocation will not be effective as to the use and/or disclosure of information I have previously authorized or where other action has been taken in reliance on an authorization I have signed.
- I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient, and if so, may not be subject to federal and state laws protecting its confidentiality.

I fully understand and accept the terms of this authorization.

_____ Date: _____/_____/_____

Signature of patient or representative

_____

Printed name of patient or representative (if applicable)

_____

Authority or relationship of representative (if applicable)