

Patient Label

YVFWC Authorization to Disclose, Release, and/or Obtain Protected Health Information

AUTHORIZATION TO DISCLOSE, RELEASE AND/OR OBTAIN PROTECTED HEALTH INFORMATION:

Recent medical records are available via MyChart for immediate download without filling out this form.



1. Patient Information

Last Name	First Name	Middle Name	Date of Birth
Email Address		Former Names and alias (if any)	Clinic/Location of Service
Doctor or Clinic Name		Phone Number (including area code)	Fax Number (including area code)
Address	City	State	Zip

2. *For the following purpose:

☐ Legal Purpose ☐ Insurance ☐ Continuity of Care/Treatment ☐ Personal ☐ Other (Specify) _____

RELEASE INFORMATION TO:

Name of Individual/Organization or Affiliation			
Telephone Number (including area code)	Fax Number (including area code)		
Address	City	State	Zip

3. AUTHORIZATION FOR ROI:

*I authorize the following services and/or programs to disclose information from my records. I understand that information may be provided orally, by mail, fax, electronically, or by hand delivery.

4. Date Range: _____ to _____ OR ☐ Most Recent 2 Years (default if no dates listed)

MEDICAL/OB

☐ Immunization History ☐ Last 2 Years of Consultations ☐ Last 2 Years of Progress Notes ☐ Medication List ☐ Problem List of Health Summary ☐ Consultation Reports relating to Pregnancy and Antenatal ☐ Delivery Records ☐ Prenatal Labs ☐ Prenatal Records (current & past) ☐ Imaging Reports/Ultrasounds ☐ Other (specify): _____	☐ Behavioral Health Services Records: ☐ Medical and Medication ☐ Discharge/Termination Summary ☐ Education/Special Education ☐ Special Edu Plan (IEP/504) ☐ Multidisciplinary Testing ☐ Academic Records ☐ Disciplinary Records ☐ Attendance Records ☐ Psychiatric/Mental Health Notes ☐ Other (specify): _____ ☐ BHS Substance Use Disorder Treatment Records	The following services only (check all that apply): ☐ Community Health Service Records ☐ WIC Records ☐ New Hope Records ☐ NCAC Northwest Community Action Center ☐ Cures Act, all EHI (If selected forward to HIPAA Privacy Officer)
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PEDIATRIC

☐ Consultation Reports ☐ Education Evaluations ☐ Evaluation & Therapy Reports	☐ Growth Chart ☐ Immunization History ☐ Last 2 Well Child Visits	☐ Progress Notes ☐ Medication List ☐ Problem List or Health Summary
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DENTAL

- ☐ Most Recent Perio
- ☐ Most Recent Bite Wings
- ☐ Dental Summary
- ☐ Perio Chart
- ☐ Dental Records
- ☐ Other (specify): _____

5. *I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse.

*I give my permission to release the following records (check all that apply):

- ☐ HIV/AIDS and STD/STI test results, diagnosis, or treatment records (RCW 70.24.105), (OAR 333-12-270(8)(a))
- ☐ Genetic information (ORS 659.710, 659.715, 659.720)
- ☐ Mental health records (RCW 71.60.390 or 71.34200) Including: (ORS 179.505)
- ☐ Substance Use disorder (SUD) Information and records (42 CFR Part 2)

6. DELIVERY METHOD:

Please deliver my information:

- ☐ In Paper Form By Mail
- ☐ In Electronic Form by MyChart - **Please engage email alerts by my selection of MyChart communication.**
- ☐ In Electronic Form with format and method determined by YVFWC
- ☐ In Oral Form (e.g., School Nurse, Attorney, Others involved directly in my care.)

PLEASE READ BELOW CAREFULLY:

7. *I understand that my records are protected under the Federal regulation, Oregon and Washington state laws and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

8. * I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to YVFWC, Attn: HIPAA Privacy Office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides insurer with the right to context a claim under my policy. Unless otherwise revoked, this authorization will expire on the follow date, event or condition:

_____ If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days.

Date

9. *I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact YVFWC HIPAA Privacy Officer.

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10. *I understand that when requesting through MyChart, a copy of my medical records will be released to MyChart and will be available for viewing/downloading for 30 days from the received date. I understand that if I want to view and/or download my medical records after 30 days I will need to re-submit a request via MyChart portal.¹

Patient Signature	Printed Name	Date	Time
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Parent or Legal Representative Signature	Printed Name	Date

Witness Signature	Printed Name	Date	Time
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If I am not the person whose records are being released, I am authorized to sign because I am the:

☐ Parent ☐ Legal Guardian (attach copy of court order) ☐ Other: _____

Minors: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care; (2) sexually transmitted diseases (if age 14 and older); (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).

Deceased: If you are requesting copies of records for a person who is deceased, a copy of the death certificate is required.

¹ Adult Proxy, Limited Minor Proxy, and Adolescent Full Proxy will allow the proxy to submit a request through MyChart and to download the patient's health information requested, once approved via MyChart.