



**Oregon Health & Science University**  
**Hospitals and Clinics**  
**Health Information Services /**  
**Medical Correspondence**  
 3181 SW Sam Jackson Park Rd,  
 Mail Code: OP17A  
 Portland, OR 97239-3098  
 (503) 494-8521, Fax (503) 494-6970

ACCOUNT NO.  
 MED. REC. NO.  
 NAME child Name  
 BIRTHDATE DOB

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**  
 ALL SECTIONS OF THIS FORM **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize: OHSU  
(Name of person / entity/ facility disclosing information)  
 \_\_\_\_\_  
(Address of person / entity) (City) (State) (Zip Code)

to use and disclose an electronic copy of the specific health information described below; unless you check here  for a paper copy. This release is regarding:

Name of child  
(Name of individual)  
 consisting of: (see back side for definitions)  Physician reports  X-rays (please see the back side of this form for complete instructions)  Labs  ED  Billing  Radiology Report  
 Other, specify accommodations, medications, food substitutions  
 If outpatient practice/clinic records are needed, please specify the practice(s)/clinic(s) (see back side for practice/clinic list) PLEASE GET NAME OF CLINIC AND DOCTOR  
 to: Southern Oregon Head Start  
(Name of recipient)  
1001 Beall Lane, Po Box 3697 Central Point, OR 97502  
(Address of recipient) (City) (State) (Zip Code)

for the purpose of: (Describe each purpose of disclosure)  Continued Care  Legal  Disability  
 School Entry  Other, specify write in anything else needed

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 only if I place my **initials** in the applicable space next to the type of information.

- HIV/AIDS information
- Mental health information
- Genetic testing information
- Drug/alcohol diagnosis, treatment, or referral information

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. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Medical Correspondence, Health Information Services, OP17A, OHSU 3181 SW Sam Jackson Park Rd. Portland, OR 97239-3098, and state that you are revoking this authorization

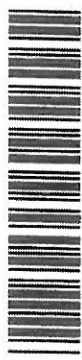
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic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

**I have read this authorization and I understand it.**

This authorization expires one year from the date of signing unless revoked or otherwise specified below:  
(Enter alternative expiration date or event)

By [Signature] (Signature of individual or personal representative) Date: \_\_\_\_\_ Time: \_\_\_\_\_

Description of personal representative's authority: \_\_\_\_\_





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*Patient Identification*

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**DEFINITION OF REPORTS:**

- Physician reports include Discharge Summary, Discharge instructions, History & Physical exam, any procedures or operations
- X-rays include X-ray reports, Ultra sound, MRI, and special Imaging reports (If you are requesting for an actual image please make sure to fill out the Authorization Form MR-4775) The form may be accessed at the following web site: <http://ozone.ohsu.edu/healthsystem/HIS/mr4775.pdf>
- Labs – all laboratory test results
- ED – Emergency Department reports by physician
- Billing – Hospital and / or clinic billing information
- Immunizations – all immunization records
- Other – Specify information not listed

**OHSU OUTPATIENT PRACTICES/CLINICS:**

Adult Psychiatry  
Allergy & Immunology  
Anticoagulation  
Audiology  
Bone & Mineral  
Bone Marrow Transplant / Leukemia  
Cardiology  
Casey Eye Institute  
CDRC Eugene  
Center for Women's Health  
Child and Adolescent Psychiatry  
Childhood Development and Rehabilitation (CDRC)  
Comprehensive Pain Center  
Dermatology  
Dermatology Surgery  
Diabetes  
Digestive Health  
Doernbecher Pediatrics - Westside  
Employee Health  
Endocrinology  
Executive Health  
Family Medicine at South Waterfront  
Gabriel Park  
Gastroenterology  
General Pediatrics  
General Surgery  
GI / Hepatology  
Health Promotion and Sports Medicine  
Hematology / Oncology

Infectious Disease  
Intercultural Psychiatry Program  
Internal Medicine  
Knight Cancer Center/Community Hematology Oncology  
Lipids  
Liver Transplant  
Marquam Hill Internists  
Nephrology & Hypertension  
Neurology  
Neurosurgery  
Oral & Maxillofacial Surgery  
Orthopaedics  
Otolaryngology  
Pediatric Hematology / Oncology  
Pediatric Specialties  
Perinatal  
Plastic Surgery  
Pulmonary  
Radiation Oncology  
Renal Transplant  
Rheumatology  
Richmond  
Riverplace  
Scappoose  
Sleep Medicine  
Surgical Oncology  
Urology  
Vascular Surgery